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A Survey of Music Therapists Working in Acute Care, Adult Psychiatric Facilities in the United States: Theoretical Orientations and Practices

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This research was completed as part of the degree requirements for the Music Therapy Department at Molloy College.

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For the degree of Master of Science

In Music Therapy

by

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MOLLOY COLLEGE

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A Master's Thesis Submitted to the Faculty of

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May 2018

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Abstract

The purpose of this study was to investigate the theoretical orientations and practices of music therapists working in acute care, adult psychiatric facilities (ACAPF) across the US. The study utilized quantitative research strategies, employing an online, questionnaire-based survey. Responses were analyzed to determine the music therapists' primary theoretical orientations, whether there were significant differences among the orientations with respect to demographics, working environments, and approaches/methods, as well as whether there were geographic concentrations of theoretical orientations. Most respondents identified as having a behavioral/cognitive behavioral, humanistic/existential, or psychodynamic theoretical orientation. The survey results indicated statistically significant differences among the three orientations with respect to age, unit size in terms of patients, typical length of stay of patients, the importance of group members' musical experiences being generalizable to settings outside of a musical setting, the importance of group members gaining some degree of insight into their mental condition, the use of improvisation and re-creative methods, and whether group improvisations are considered structured or free. The implications for music therapy are discussed.

Keywords: acute psychiatry, music therapy, theoretical orientation, approaches, methods

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A Survey of Music Therapists Working in Acute Care, Adult Psychiatric Facilities in the United States: Theoretical Orientations and Practices

This study investigated the theoretical orientations and practices of music therapists working in acute care, adult psychiatric facilities (ACAPF) across the US. For this study, an ACAPF was defined as a locked facility or unit, with a typical length of patient stay of approximately 2-4 weeks. The researcher analyzed responses received from music therapists working in these facilities to determine the music therapists' primary theoretical orientations and the music therapy methods they used, whether there was a relationship between the two, and whether there were geographic concentrations of theoretical orientations. This study utilized quantitative research strategies, employing an online, questionnaire-based survey.

Terminology

It is important to define certain terms used throughout this study that refer to how music therapists conduct their work. Although the general meanings of these terms are believed to be understood, specific definitions of the terms are not applied consistently across the music therapy profession.

For this study, a music therapist's **theoretical orientation** is defined as the *primary* psychotherapeutic theory with which the music therapist aligns. Although many music therapists working in the field of mental health consider their orientation to be eclectic (Silverman, 2007), Wigram, Pederson, and Bonde (2002) point out that some argue it is not possible to be an eclectic music therapist who switches orientation from one client to another to meet clients' specific needs. A music therapist's orientation influences the way he or she views and interacts with patients, as well as to what music therapy models, approaches, and methods he or she is attracted.

Humanism, psychodynamic psychotherapy, and behaviorism are common theoretical orientations for music therapists. According to Corey (2013), humanism entails "a respect for the client's subjective experience, the uniqueness and individuality of each client, and a trust in the capacity of the client to make positive and constructive conscious choices" (p. 176). Gabbard (1990) defines psychodynamic psychotherapy as "an approach to diagnosis and treatment characterized by a way of thinking about both patient and clinician that includes unconscious conflict, deficits and distortions of intra-psychic structures, and internal object relations" (p. 4). Behaviorism focuses on "directly observable behavior, current determinants of behavior, learning experiences that promote change" (Corey, 2013, p. 247).

Bruscia (2014) defines a **model** as "a comprehensive approach to assessment, treatment, and evaluation which includes theoretical principles, clinical indications and contraindications, goals, methodological guidelines and specifications, and the characteristic use of certain procedural sequences and techniques" (p. 129). Analytical Music Therapy (AMT), the Bonny Method of Guided Imagery and Music (BMGIM), Creative Music Therapy (CMT), and Behavioral Music Therapy (BMT) are examples of models used by music therapists working in the mental health field.

AMT is "an active, psychotherapeutic method based on symbolic use of musical and non-verbal improvisations followed by an interpretive therapeutic dialogue between therapist and client" (Trondalen & Bonde, 2012, p. 45). BMGIM is a receptive approach to music psychotherapy which uses specifically designed programs of classical music. According to Pickett (2002), "GIM reaches the deeper layers of the psyche and brings that material to conscious awareness for examination and resolution" (p. xxv). CMT is a model based upon improvised music. It was developed by Paul Nordoff and Clive Robbins, who were influenced

by the anthroposophical movement in humanistic psychology. Central to CMT is "the idea that within every human being there is an innate responsiveness to music, and within every personality one can reach a 'music child' or a 'music person'" (Trondalen & Bonde, 2012, p. 47).

According to Trondalen and Bonde, BMT, which is closely related to behavioral theory, has likely had the most significant impact on music therapy education in the US. Clifford Madsen, one of the early developers of BMT, described it as a type of cognitive-behavior modification using music. Bruscia (2014) states that with BMT, "the therapist uses music to increase or modify adaptive (or appropriate) behaviors and to extinguish maladaptive (or inappropriate) behaviors" (p. 214).

An **approach** is another dimension that can be used to describe how music therapists perform their clinical work. As Mössler, Chen, Heldal, and Gold (2011) explain, "approaches in music therapy may also be described by their modality ('active' versus 'receptive'), their level of structure, and the focus on the music itself versus on verbal processing of the music experiences" (p. 6). Although other aspects of a therapist's clinical work could also be described as approaches, this study focuses on the three mentioned by Mössler et al. Regarding the use of music versus verbal processing in the therapeutic process, Bruscia (1998) has described the concept of music *as* therapy as occurring when the therapeutic process happens either entirely through music, or when verbalization occurs, but only to interpret or enhance the music experience. Alternatively, Bruscia describes the concept of music *in* therapy as occurring when the therapeutic process happens either equally through music and verbalization, or when the process occurs primarily through verbalization.

Bruscia (2014) defines a **method** as "a particular type of music experience used for assessment, treatment, and/or evaluation" (p. 128). He delineates four main methods of music therapy: improvising, re-creating, composing, and listening (receptive). According to Bruscia, "In improvisational music experiences, the client makes up music while playing or singing, extemporaneously creating a melody, rhythm, song, or instrumental piece" (p. 130). "In re-creative experiences, the client learns, sings, plays, or performs precomposed music or reproduces any kind of musical form presented as a model" (p. 131). "In composition experiences, the therapist helps the client to write songs, lyrics or instrumental pieces, or to create any kind of musical product such as music videos or audiotapes" (p. 133). "In receptive experiences, the client listens to music and responds to the experience silently, verbally, or in another modality" (p. 134).

Personal Background and Interest in Topic

As a 55-year-old male who spent 28 years as a financial analyst in New York City's (NYC) financial district, I do not fit the profile of a typical music therapy student. I've always loved music (I played piano through high school and started drumming as a hobby when I was 36 years old), and I had imagined I would do something related to music once I retired. However, with the advent of the financial crisis in 2008, I found the working environment in the financial district to be increasingly miserable, and I determined that I did not want to stay there until I retired.

Over the course of my career as a financial analyst, my initial blind faith in unfettered capitalism was eroded by witnessing firsthand the destruction and heartache that greed can cause. On a personal level, I evolved from being someone with little interest in helping others to having a definite desire/need to do something in my life that would be helpful to other people. In

retrospect, I believe my increasing desire to help others was a manifestation of my progression through Maslow's hierarchy of needs (Corey, 2013).

As the financial crisis progressed and I was searching for a possible new career, I came across the field of music therapy, which I thought would be a great combination of my love of music and desire to help others. After being accepted into a program, as part of my studies I did clinical practicum work with older adults in a nursing home, children on the autism spectrum, and adolescents/young adults with intellectual disabilities. But it was the patients in an ACAPF that I felt the strongest connection to and personally found the most interesting to work with.

I enjoy the wide range of musical interests I encounter working with adults with psychiatric disorders. I try to be aware of my countertransference with the many patients who remind me of someone I either grew up with, went to school with, or worked with, and I believe these feelings strengthen my ability to empathize with the patients' difficult circumstances. I find the ways in which the various permutations of different pathologies manifest themselves in human behavior to be infinitely fascinating.

I also find the relatively rapid patient turnover at acute care facilities to be challenging and exciting. Because of the rapid turnover, as well as the evolving mental state of individual group members, no two groups are the same. I love the challenge of working with different groups of patients with varying levels of psychosis, being able to give them the opportunity to express themselves creatively, and providing a structure for combining their individual efforts into a whole experience that can sometimes be spectacular. Nachmanovitch (1990) states, "As stone is to a sculptor, so time is to a musician. Whenever he gets up to play, the musician stands there facing his own unsculpted block of time" (p. 31). I view the start of each group as though the group is being presented with an unsculpted block of time, and I am always anxious, curious,

and fascinated to see what musical experiences the group will create out of that block of time. It makes me feel like an artist, and I love that!

From an epistemological perspective, I am aligned with interpretivism. I feel the problem with the objectivist view of there being one reality is that it does not apply very well to the social sciences, where there can be multiple perceptions of reality. Even in my prior experience with the world of finance, some companies could be viewed as having either very strong or very weak financial positions, depending upon what accounting methodology was applied.

Although I align with interpretivism, I chose the objectivist methodology of survey research to conduct this study because I believe it is the methodology that addresses the study's underlying research questions most effectively. However, even though a survey is considered an objectivist research instrument, this study's survey contained a few questions where the respondents had personal discretion in how they answered. Rather than providing definitions or guidelines for how to answer the questions, I was more interested in learning how the respondents perceived themselves and their approaches.

Since embarking upon my studies to become a music therapist, I have worked (as a clinical practicum student, intern, or employee) at four different ACAPFs on Long Island and in Brooklyn and Queens. During this time, I have been intrigued by the apparently different theoretical orientations of the music therapists at each site, and how the differing orientations seem to influence the kinds of musical experientials/interventions they use. As a financial analyst, my work consisted primarily of determining the strength of companies' financial positions and comparing various companies with each other. Given that I performed that type of work for nearly 3 decades, I believe it is now part of my innate nature to want to compare similar

entities, including my workplaces. At one ACAPF where I worked, my supervisor's philosophical orientation was primarily behavioral, and the methods utilized were primarily re-creative in nature, with virtually no improvisational work done. At another facility, the orientation of the music therapy staff members was humanistic and psychodynamic, and virtually all the methods employed were improvisatory.

As a music therapist, I consider myself to work humanistically, striving to meet the patients where they are with respect to their mental condition and their capabilities. I attempt to engage patients in improvisational experientials to the extent they are willing and/or able, and when using re-creative methods, I again try to engage patients to as great an extent as they are capable. I firmly believe in and practice music *as* therapy.

In the past few years, I have attended several music therapy conferences where I have had the opportunity to meet and speak with music therapists from outside the NYC area. After these interactions, I was left with the impression that the NYC area is a bastion of music therapists using primarily humanistic and psychodynamic approaches in their work, while behaviorism seemed to be the more prevalent approach in other places. Because of my work experiences and conversations with non-NYC music therapists, I was interested in conducting research to investigate the theoretical orientations used by music therapists working in ACAPFs. This research assists in determining if there is a relationship between these music therapists' theoretical orientations and the types of methods they utilize, learning whether theoretical orientations vary geographically across the US and determining if there are concentrations of specific orientations in certain geographic locations.

The Need for this Research in the Profession

Why focus specifically on music therapists working with *acute* psychiatric patients? In the experience of this researcher, there are four aspects of the acute psychiatric care environment that distinguish this population from the overall mental health population. First, when acute patients are admitted to a facility, it is because they have experienced some type of psychotic episode and/or psychological crisis, which often causes them to present with unique behaviors and challenges.

A second distinguishing feature is the facilities where acute psychiatric patients receive treatment, which are "locked," meaning that patients are not able to leave a facility until their treatment team determines that they are ready for discharge. The fact that patients cannot leave a facility under their own volition can contribute to agitation and feelings of frustration and anxiety, which can manifest themselves in a patient presenting with threatening behavior towards other patients and staff. A third distinguishing feature of the care provided to acute psychiatric patients is the relatively brief treatment period. Given the generally short amount of time music therapists have to work with these patients, the question arises as to what types of interventions can be utilized to work most effectively with them.

Park's (2011) research raises a fourth, unique aspect of working with acute psychiatric patients, which is the relatively rapid patient turnover. Due to frequent admissions and discharges, group membership can vary daily. Additionally, the mental state of individual group members can vary each day, depending upon how they are responding to their prescribed medications.

From the researcher's viewpoint, it is this fourth aspect that makes working with the acute population especially challenging and exciting. Given the fluctuating membership of a

unit's music therapy group and the evolving mental states of the group's members, every group session that is conducted is truly a unique experience. The questions arise: How does a music therapist prepare for a group session where the composition of the membership is unknown? What type of conceptual framework does a music therapist use in determining what methods to use to effectively provide the greatest therapeutic benefit to the group's members and, in a broader context, to the unit's patients?

The unique aspects of the acute psychiatric care environment suggest that a specific manner of working with these patients is warranted. However, a main conclusion of Carr, Odell-Miller, and Priebe's (2013) systematic review of music therapy practices and outcomes with acute, adult psychiatric inpatients was that there was no well-researched, well-defined music therapy model being used in ACAPFs.

This research study is the first to target specifically and exclusively music therapists working in ACAPFs in the US. I view this study as a first step in building a possible foundation to a more consistent approach in working with acute psychiatric patients. I believe that before we, as a profession, can decide where we want, or need, to go with respect to developing a more consistent approach, we first need to determine where we are.

Methodology and Research Questions

The objectivist methodology of survey research was utilized for this study. The research questions were:

1. What percentage of music therapists working in ACAPFs in the US align most closely with humanistic/existential, behavioral/cognitive behavioral, or psychodynamic theoretical orientations?

2. What percentage of the music therapists' clinical work consists of improvisational, re-creative, compositional, and receptive music therapy methods?

3. Is there a relationship between a music therapist's primary theoretical orientation and the music therapy methods he or she uses?

Literature Review

The purpose of this study is to explore the theoretical orientations and practices of music therapists working in ACAPFs. Although surveys are a common method for obtaining data within the music therapy profession, the literature is relatively sparse with respect to surveys conducted with music therapists working in the broad field of mental health, and the researcher could find no published survey research focusing specifically on music therapists working in acute care, adult psychiatry. In this section, a review of the literature regarding the use of music therapy with acute, adult psychiatric patients is first provided. This is followed by a discussion of research studies addressing the theoretical orientations of music therapists working in the mental health field, and the music therapy models, approaches, and methods that these music therapists use in their clinical work. The section concludes with a review of the results of recent surveys conducted with music therapists working within the field of mental health in the US.

Music Therapy in Acute Care, Adult Psychiatry

Why focus specifically on music therapists working with *acute* psychiatric patients? As mentioned previously, the acute psychiatric care environment has several unique aspects that distinguish it from the overall mental health population, suggesting that a specific manner of working with these patients could be warranted. However, Carr et al. (2013) conducted a systematic review of 98 studies (including 32 from the US and 17 from the United Kingdom) of music therapy practices and outcomes with acute, adult psychiatric inpatients and concluded that, though different music therapy models for the broader field of mental health care had been developed, there was no well-researched, well-defined music therapy model specifically designed for acute care, adult psychiatric patients.

One distinguishing feature of the facilities where acute psychiatric patients receive treatment is that they are locked facilities, meaning that patients are not able to leave a facility until their treatment team determines they are ready for discharge. Shattell, Andes, and Thomas (2008) conducted a phenomenological study of patients and nurses in an acute care psychiatric unit to investigate how they felt about their living and working environments, respectively. Patients described the environment as, "a place where they were imprisoned and confined 'like a caged-in animal.' Their descriptions were dominated by feelings of powerlessness, intimidation, harassment, suffocation and control" (p. 245).

Music therapy can be effective in countering the negative feelings acute psychiatric patients may experience while being confined during their treatment. MacDonald (2015) conducted a phenomenological study of patients hospitalized in an acute psychiatric facility in which the patients were asked to describe their experiences in group music therapy treatment. Common themes that arose from their experiences included: release of stress, healing balm, safe space, coping with here and now/hospitalization, motivation/hope, and connection to others.

Another distinguishing feature of the care provided to acute psychiatric patients is the relatively brief treatment period. Markovich and Tatsumi (2015) conducted a quasi-experimental study to research the impact of single-session music therapy groups versus cognitive-behavioral therapy (CBT) groups on the mood of acute psychiatric patients. The study's participants attended either an active music group (AMG), receptive music group (RMG), or CBT group. The methods utilized by the AMG were playing instruments, singing, and songwriting, while the RMG utilized song discussion. The CBT group focused on the needs and issues of the patients for that day. Although each of the groups experienced an improvement in mood during their sessions, the RMG was the only one that experienced a statistically significant change.

The research of Gold, Solli, Krüger, and Lie (2009) documented the importance of music therapy sessions conducted in ACAPFs. They investigated whether there is a positive correlation between the number of music therapy sessions (dose) a person with a serious mental disorder receives and the extent of their recovery (response) and determined that such a relationship does exist. Their study determined that benefits of music therapy can be seen after only a few sessions, which would be typical of the sessions conducted on an acute inpatient unit. Their findings also suggest that the dose-response relationship may be nonlinear, that is, increasing more steeply with the first few sessions than in later sessions, for negative symptoms and functioning, again pointing to the relative importance of the music therapy sessions conducted in ACAPFs.

Further reinforcing the importance of music therapy conducted in ACAPFs, Ulrich, Houtmans, and Gold (2007) researched the effect of music therapy on inpatients with schizophrenia requiring acute care, using a randomized controlled trial (RCT). Patients were randomly assigned to an experimental group and a control group, with the experimental group receiving group music therapy in addition to regular medication, with standard treatment received by both groups. The researchers described the therapeutic method used in the music therapy sessions as "eclectic with behaviouristic accents" (p. 363). Music therapy was found to have significant effects with respect to the patients' self-evaluation of their psychosocial orientation and for negative symptoms. The researchers noted that the impact on negative symptoms is particularly important because medications have had only a modest impact in improving negative symptoms.

More recently, Morgan, Bartrop, Telfer, and Tennant (2011) performed a quasi-randomized controlled trial to investigate the effect of music therapy on acute psychiatric

patients. The authors explained that the originally intended randomization process was changed to a quasi-randomized design because of safety concerns arising from patients being able to discern whether they had been assigned to the treatment or control group. With the quasi-randomized design, in one month all participating patients were assigned to the treatment group, and the following month the next group of participating patients were assigned to the control group. Their research showed significant decreases in Brief Psychiatric Rating Scale scores for those participants receiving music therapy, compared to those who did not. Although the treatment group experienced a 9% decrease in their length of stay at the hospital relative to the control group, this difference did not reach statistical significance. However, the authors noted that the decreased length of stay did lead to considerable cost savings for the hospital.

Theoretical Orientations of Music Therapists

A music therapist's theoretical orientation, whether he or she is aware of it or not, serves as a foundation for how he or she conducts their work and relates to his or her patients and/or clients. Music therapists who are conscious of their theoretical orientations at least have a framework for determining which models, approaches, and methods they will likely feel most comfortable aligning themselves with and utilizing in their clinical work. Choi (2008) surveyed 500 music therapists chosen randomly from the Certification Board for Music Therapists' (CBMT) list of music therapists residing in the US to identify their theoretical awareness of their practices and determine factors influencing specific theoretical orientation. The research findings indicated that a music therapist's theoretical orientation is dependent upon the college he or she attended, his or her area of practice, and his or her age group.

Park (2011) conducted a descriptive analysis in which three music therapists working in different psychiatric facilities participated in semi-structured interviews, with each therapist

primarily identifying himself or herself as working in either a humanistic, psychodynamic, or cognitive-behavioral theoretical framework. Data were analyzed using the constant comparative method with the interview transcriptions being segmented, coded, and categorized to identify themes. Although the two therapists who identified as being humanistic and cognitive-behavioral worked in acute care facilities, the therapist identifying as psychodynamic worked in a longer-term facility where the average length of stay was over 5 years. Though all three therapists used improvisational methods in their sessions, the way in which they used improvisation differed. The humanistic therapist utilized more free form improvisations in which he initially led the group but then shifted to having the patients take the lead. Alternatively, the cognitive-behavioral therapist used more structured improvisations that usually had a predetermined theme associated with them.

Researching the possibility that spiritual belief would be a predictor of music therapists' theoretical orientations, Potvin (2013) found no significant relationship. Interestingly, 83% of the study's 60 respondents identified their primary clinical population to be mental health. Regarding their primary theoretical orientation, 55% of the respondents identified as humanistic/person-centered/experiential, 40% chose cognitive/behavioral, and 3% selected psychodynamic/psychoanalytic. Potvin also analyzed how the responses were dispersed among the seven geographic regions designated by AMTA. This analysis showed that all respondents from the Mid-Atlantic Region identified as humanistic/person-centered/experiential, while 71% of respondents from both the New England and Western Regions identified as humanistic/person-centered/experiential. Respondents from the Southeastern Region were evenly divided between humanistic/person-centered/experiential and cognitive/behavioral

orientations, while 83% of respondents from the Great Lakes and 70% of respondents from the Southwestern Regions identified as cognitive/behavioral.

Music Therapy Models Used in Mental Health

As stated earlier, Bruscia (2014) defined a music therapy model as "a comprehensive approach to assessment, treatment, and evaluation which includes theoretical principles, clinical indications and contraindications, goals, methodological guidelines and specifications, and the characteristic use of certain procedural sequences and techniques" (p. 115). Given the unique aspects of working with acute psychiatric patients discussed earlier, it seems that having a model for working with this population would be beneficial to the field. However, as Carr et al. (2013) pointed out, none of the few music therapy models that have been developed and are in general use for mental health care was designed specifically for acute care, adult psychiatric patients.

The Bonny Method of Guided Imagery and Music (BMGIM) is a receptive form of music psychotherapy in which clients verbally describe imagery they are experiencing while listening to classical music selections chosen by the music therapist. Wrangsjö and Körlin (1995) note that BMGIM differs from traditional psychodynamic therapy because of its ability to draw upon a client's strengths, competencies, and creativity. Wrangsjö and Körlin conducted a pre-post study to research the impact of BMGIM on the psychiatric symptoms and interpersonal relationship issues of 14 outpatients and found there was a decrease in most symptoms and a significant decrease in interpersonal problems. Although concluding that their results appear to have positive implications regarding the use of BMGIM with psychiatric patients, the researchers noted that the use of BMGIM with patients with acute psychoses is contraindicated because of the weak ego strength and defensive capacity of these patients. Referring to Bruscia's (1998) discussion of music *as* therapy and music *in* therapy, BMGIM is an example of music *as* therapy.

Analytical Music Therapy (AMT) incorporates psychoanalytical concepts and was developed in the early 1970s by Mary Priestley "as an active, psychotherapeutic method based on the symbolic use of musical and non-verbal improvisations followed by an interpretive therapeutic dialogue between therapist and client" (Trondalen & Bonde, 2012, p. 45). The musical improvisations tend to be referential, based upon a theme discussed beforehand by the therapist and client, reflecting a challenge or issue the client is facing. Priestley viewed the verbal processing following the improvisation to be as important in the therapeutic process as the improvisation itself, and thus AMT is an example of music *in* therapy.

As its name implies, Behavioral Music Therapy (BMT) is based on the principles of behavioral theory, with music being used to modify a patient's behavior through conditioning. Many forms of behavior, including psychological and emotional, can be modified. According to Trondalen and Bonde (2012), "The therapeutic process is based on a stimulus-response paradigm, and as a dependent variable the music must be controlled. This explains why specific music, often recorded, is preferred to, for example, improvisation in the treatment of patients" (p. 50). Given the need for predictability and control of the musical stimulus, session formats are firmly structured. BMT is an example of music *in* therapy.

Although Paul Nordoff and Clive Robbins developed Creative Music Therapy (CMT) originally through their work with children on the autism spectrum and those with learning disabilities, it has subsequently been used with psychiatric patients, and many of its underlying principles are congruent with working with acute patients. The development of CMT was influenced by humanistic psychology, and CMT incorporates many aspects of music-centered music therapy. As Aigen (2014) pointed out, CMT does not align with behavioral principles. He wrote that CMT "focuses on behavioral manifestations not as items of interest in their own

right but as reflections of the inner dynamics, structures, strengths, and limitations of a person's being. The idea is not simply to alter behaviors but to provide an alternative blueprint for the formation of a more functional, healthier personality structure" (p. 23). CMT makes extensive use of improvisational methods and is an example of music *as* therapy.

Music Therapy Approaches

The approaches music therapists incorporate in their work may be related to their theoretical orientations. Although the term "approach" can apply to several different dimensions of clinical work, the dimensions focused on in this study are the level of structure and whether the emphasis is on the music itself or on verbal processing as the primary agent of change within the therapeutic process. Approaches can vary among the different orientations because the orientations are more congruent with certain approaches than others. For instance, while a behavioral orientation implies a high degree of structure, it does not necessarily imply a high level of verbal processing. Conversely, while a psychodynamic orientation can imply a relatively high degree of verbal processing, it does not necessarily imply a high degree of structure. Finally, while a humanistic orientation can be congruent with high levels of both structure and verbal processing, it is the only one of the three orientations focused on in this study that is also congruent with concurrently low levels of structure and verbal processing.

The first online survey of Israeli music therapists regarding their theoretical orientations and clinical work was conducted by Wiess, Dassa, and Gilboa (2017). Their questionnaire included inquiries regarding approaches the respondents used in their work. Among the respondents, there were significant differences between those therapists with more than 8 years of experience and those with less than 8 years of experience. In general, the younger therapists utilized more varied techniques, were proficient with more instruments, and used music more *as*

therapy. A higher percentage of younger therapists also identified their theoretical orientation as being either psychodynamic or humanistic.

Garred (2004) conducted a philosophical inquiry into the roles of music and verbal processing in music therapy, that is to say, the concepts of music *as* therapy, and music *in* therapy. He used CMT and AMT as examples showing "two different roles to music, mainly as a *symbolic projection* of the individual psyche in AMT, or as a personal *aesthetic expression*, in CMT. The proposition is that in CMT music is not regarded primarily as projective device for the inner state of the client. It is itself related to, in its full aesthetic significance as music, which transcends the private and merely autobiographical" (p. 348). Garred viewed the use of verbal processing within a music *in* therapy approach to be problem-oriented, providing a means for the therapist and client to work through issues brought to the conscious surface through a preceding musical interaction. On the other hand, a music *as* therapy approach was viewed as resource-oriented, "not directed towards working through conflict. It is a positive - in the sense of enhancing resources - rather than a negative approach - conceived of as removing hindrances" (p. 351).

Another dimension of approach that can vary by therapists is the amount of structure utilized in their interventions. According to Wigram (2002), the "value of therapeutic development is the fostering of flexibility and creativity with a structured frame. Music can be structured and safe, but in a useful and challenging way; it can also be unstructured and 'unsafe', whilst still being a positive experience" (p. 11). Although Wigram's comments were written regarding people with autism spectrum disorders, they are also applicable to patients with acute psychiatric problems.

Music Therapy Methods

As mentioned earlier, Bruscia (2014) delineated the four main methods of music therapy as improvising, re-creating, composing, and listening (receptive). Although the methods employed by a music therapist are likely a direct manifestation of his or her theoretical orientation, any of the methods can be used congruently within any of the orientations focused on in this study. However, for any given method, specific interventions/experientials will likely vary by theoretical orientation due to the different approaches implied by the different orientations.

Baker, Wigram, Stott, and McFerran (2008) conducted an international survey to investigate music therapists' use of songwriting. In their review of the literature, the authors found that most existing research had been done in the US and Australia, with little conducted in the UK and Europe. The authors surmised, "This difference may be due to the primarily psychodynamic/analytical and improvisational models practiced in Europe when compared with the more eclectic approaches practiced in the USA and Australia" (p. 107). Of the survey respondents who indicated they used songwriting, 92% were from the US/Canada, and 25% indicated the clinical population they worked with as being "psychiatry." Within the category of "psychiatry," most of the respondents worked with patients experiencing trauma (28%), schizophrenia (26%), depression and suicide (26%), and substance abuse (10%). Although there was no statistically significant difference in the frequency of use of songwriting with different diagnoses, it was utilized less frequently with those patients with schizophrenia and other psychoses. With respect to targeted goal areas, social skills was cited more frequently with those with schizophrenia and psychoses, and validating thoughts and feelings was cited less frequently by respondents working with that population.

The use of improvisation with psychiatric patients was discussed by Stephens (1983), who pointed out that through the use of percussion and melodic percussion instruments, virtually all patients are able to participate, regardless of musical training. Citing CMT as an example, she noted, "Through spontaneous musical interaction, the relationship between therapist and client is developed. The improvised music provides a medium for communication, psychological organization, self-realization, and creative expression" (p. 30). She also stated, "An important element is that of an equal relationship in musical terms. It is not the therapist, a trained musician, playing beautiful music for the client, but both struggling with rhythm and non-rhythm, loud sounds and soft sounds, fast sounds and slow sounds" (p. 41).

Solli (2008) detailed a case study of his work using improvisation with a man with schizophrenia in a psychiatric inpatient unit. Solli pointed out the importance of recognizing and utilizing clients' own musical preferences. He also discussed the rhythmic aspect of "groove" and how it can help create a musical experience that is inviting for patients to join. The potential for conflict between the approaches of music *as* therapy and music *in* therapy was highlighted when, during a session, Solli unsuccessfully attempted to engage the patient in verbal dialogue, and the patient finally responded back to him, "Shut up and play!"

Surveys of Music Therapists Working in Mental Health in the US

Although several survey studies have been conducted with music therapists working in the broad field of mental health, no survey research has been published that focuses specifically on music therapists working with adult patients with acute psychiatric problems. Silverman (2007) descriptively evaluated psychiatric music therapists and their institutions, philosophies, interventions, and clinical objectives. This provided a general profile of the respondents' demographic information and theoretical orientations. The sample was professional members of

AMTA who identified themselves as working with a "mental health" population. Here, "mental health" was defined to include not only acute care, adult patients, but also chronic inpatients, all outpatients, and adolescent patients. The respondents primarily identified their philosophical orientations as being eclectic (39%), CBT (21%), behavioral (16%), or humanistic (14%). The data contained seemingly contradictory responses regarding orientations; several participants replied that they used both behavioral and psychodynamic "approaches," which are very dissimilar. Although Silverman speculated that those responses could reflect that the respondents' orientation varied depending upon the specific intervention being utilized or the specific goal/objective, it was unclear as to whether that was indeed the reason for the responses or if the respondents had made a mistake.

Areas of concern of psychiatric music therapists were also researched by Silverman (2012). Data were analyzed according to the respondents' theoretical orientations, but this was done so by combining the responses into three categories: eclectic/integrative (53% of respondents), cognitive behavioral (28%), and psychodynamic/humanistic (17%). Outpatient care was rated as the area of highest concern, and job security was the area of least concern.

Silverman (2014) surveyed psychiatric music therapists regarding supervision, including questions concerning who they supervise, and who supervises them. Thirty-eight surveys were completed and returned for a response rate of 13%. Most respondents identified their theoretical orientation as being cognitive behavioral/behavioral (42%), humanistic (39%), psychodynamic (8%), or eclectic (6%). Silverman did not analyze the data by orientation because of the small sample size.

Most recently, Eyre and Lee (2015) conducted a mixed-methods study to examine perspectives on music therapy practice in the mental health field. Quantitative data were

obtained from respondents using an online survey questionnaire, and qualitative data were collected concurrently to provide a more robust understanding of the quantitative data. The sample was professional members of the CBMT who identified themselves as working with a mental health population. Here again, "mental health" was defined to include not only acute care, adult patients, but also chronic inpatients, all outpatients, and adolescent patients. This study did not survey participants regarding their theoretical orientation but did inquire about techniques used in clinical practice. The results showed that songs were used in various ways to help achieve the goals of improving mood, identifying and working through feelings, processing issues, improving social skills, identifying coping skills, and creating group cohesion. With respect to improvisation, a higher level of structure tended to be used with lower-functioning or psychotic patients to facilitate nonverbal expression, while a lower level of structure was used with higher functioning patients. Receptive techniques were found to be used to promote mindfulness and self-soothing, and to access the imagination.

In 2007, Cassity conducted a Delphi poll where the panel members were asked to predict the outlook for psychiatric music therapy in 2016 with respect to theoretical orientations, interventions, qualifications for music therapists, and some specific scenarios. The methodology for Delphi polls was invented by the Rand Corporation in the mid-1950s and was used by the US military for predicting the effects of a massive nuclear attack. Poll results reflect a consensual prediction reached by a panel of experts. The experts achieve consensus by rating future events and then rating the same events again after viewing the ratings of the other experts on the panel.

Of the 31 panel members in Cassity's study, 45% indicated their theoretical orientation as being either cognitive behavioral or behavioral, 16% were humanistic, 16% were psychodynamic, and 16% were eclectic. The poll results showed that behavioral and cognitive

behavioral therapies were expected to be used more frequently by 2016, while the use of humanistic and psychodynamic therapies, as well as CMT, was expected to remain the same. With respect to interventions, those concerning behavior were in the top four expected to have the greatest increase in use, while those involving improvisation, listening to music, and singing were expected to have only modest increases in use.

Through this Literature Review, the researcher has argued that acute care, adult psychiatry is a unique, under-researched segment of the overall mental health segment that deserves more specific attention. The studies cited were meant to provide an overview of the various clinical working dimensions (theoretical orientations, models, approaches, and methods) of music therapy, and how they are, or are not, applicable to this population segment. It is the intent of this study to help fill the existing gap in the research literature base regarding acute care, adult psychiatry.

Method

The purpose of this study was to explore the theoretical orientations and practices of music therapists working in ACAPFs. An online, questionnaire-based survey was used for data collection (see Appendix A), and the data were analyzed to determine if significant differences existed between theoretical orientations and the approaches and methods used by the respondents. Although a survey should be a reasonable, objectivist tool for determining "truth," the researcher recognizes that the subject of theoretical orientation can be a matter of personal interpretation and difficult to measure (Wiess, Dassa, & Gilboa, 2017), and so particular attention was paid to how the orientation-related survey questions were worded, and the survey included several related questions to most accurately determine what a respondent's theoretical orientation truly was. When designing his survey questionnaire, Potvin (2013) did not include "eclectic/integrative" as a theoretical orientation option for respondents, stating:

> "Eclectic/integrative" was purposely not included in this survey because it denotes a certain level of understanding of theory and application that music therapists have not, as a collective field, yet demonstrated in the literature. Synthesizing distinct elements from opposing philosophies requires fundamental knowledge coupled with an intimate awareness of nuance; because music therapists' level of understanding of theory was unclear due to the dearth of literature, it felt prudent to not assume a high level of proficiency by adding "eclectic/integrative" (p. 41).

Following Potvin's argument, the current study's survey also did not include "eclectic/integrative" as an explicit theoretical orientation option. However, if a respondent truly

believed his or her orientation was eclectic/integrative, he or she could specify that within the "other" category.

The survey instrument contained two questions regarding the amount of structure in respondents' group sessions and whether they considered their group improvisations to be free or structured. Rather than provide guidelines for determining the level of group structure, and definitions for "free" and "structured," the researcher was more interested in learning how respondents perceived their own approaches, and it was left to the respondents' discretion how to answer those questions.

Participants

The inclusion criteria required participants to be Board-Certified Music Therapists (MT-BCs) who identified as working in an ACAPF, and who worked at least 1 hour per week in their ACAPF. The researcher procured a listing of 679 email addresses from the CBMT of MT-BCs who identified as working in the broad field of mental health. A more specific listing of music therapists working in acute care psychiatry was not available. An announcement and link were also posted to all regional AMTA Facebook pages, as well as in the Music Therapists Working in Mental Health, Music Therapists Unite!, and Music Therapy Connections Facebook groups. Additionally, snowball sampling was used, with the researcher asking eligible participants to forward the link to other MT-BCs at their facility whom they believed to be eligible participants.

There was a total of 101 responses. Because the invitational email was sent to a broader group than the targeted population, it is not possible to calculate an accurate response rate. However, the researcher believes the response rate was consistent with the results achieved by Eyre and Lee (2015), who received responses from 102 MT-BCs who could have potentially worked in inpatient, adult psychiatry. Of the current study's 101 total responses, 76 came from

the CBMT mailing list, 22 came from the Music Therapists Working in Mental Health Facebook group, and 3 came from the Music Therapists Unite! Facebook group. No responses were obtained from the postings on the regional AMTA Facebook pages.

Because 24 respondents indicated that the typical length of stay for patients in their facility exceeded 30 days, they were excluded from the analysis due to the way that an ACAPF was defined for this study. Also, because one respondent indicated that he or she worked less than 1 hour per week in their ACAPF, and one respondent did not indicate that he or she was an MT-BC, their responses were excluded from the analysis. Thus, the data analysis included responses from 75 respondents, most of whom answered most or all of the survey questions.

Procedures and Protocols

After receiving the necessary approval from Molloy College's Institutional Review Board (see Appendix B) to conduct this study, the researcher uploaded the survey instrument and the CBMT listing of emails to www.surveymonkey.com. On January 16, 2018, potential participants were emailed an invitational email/consent form (see Appendix C), including a link to complete the survey. A copy of the invitational email/consent form and a survey link were also posted to the previously mentioned Facebook pages and groups. Approximately 2 weeks later, a reminder email (see Appendix D) was sent out to potential participants on the CBMT mailing list who had not responded, and the reminder email along with a survey link was re-posted to the Facebook pages and groups. The survey was closed on February 28, 2018. SurveyMonkey was configured so that participants responding via any of the data collection sources remained anonymous to the researcher. Although it was not possible to prevent a respondent from completing the survey more than once, the researcher has no reason to suspect that any instances of this occurred.

Data Analysis

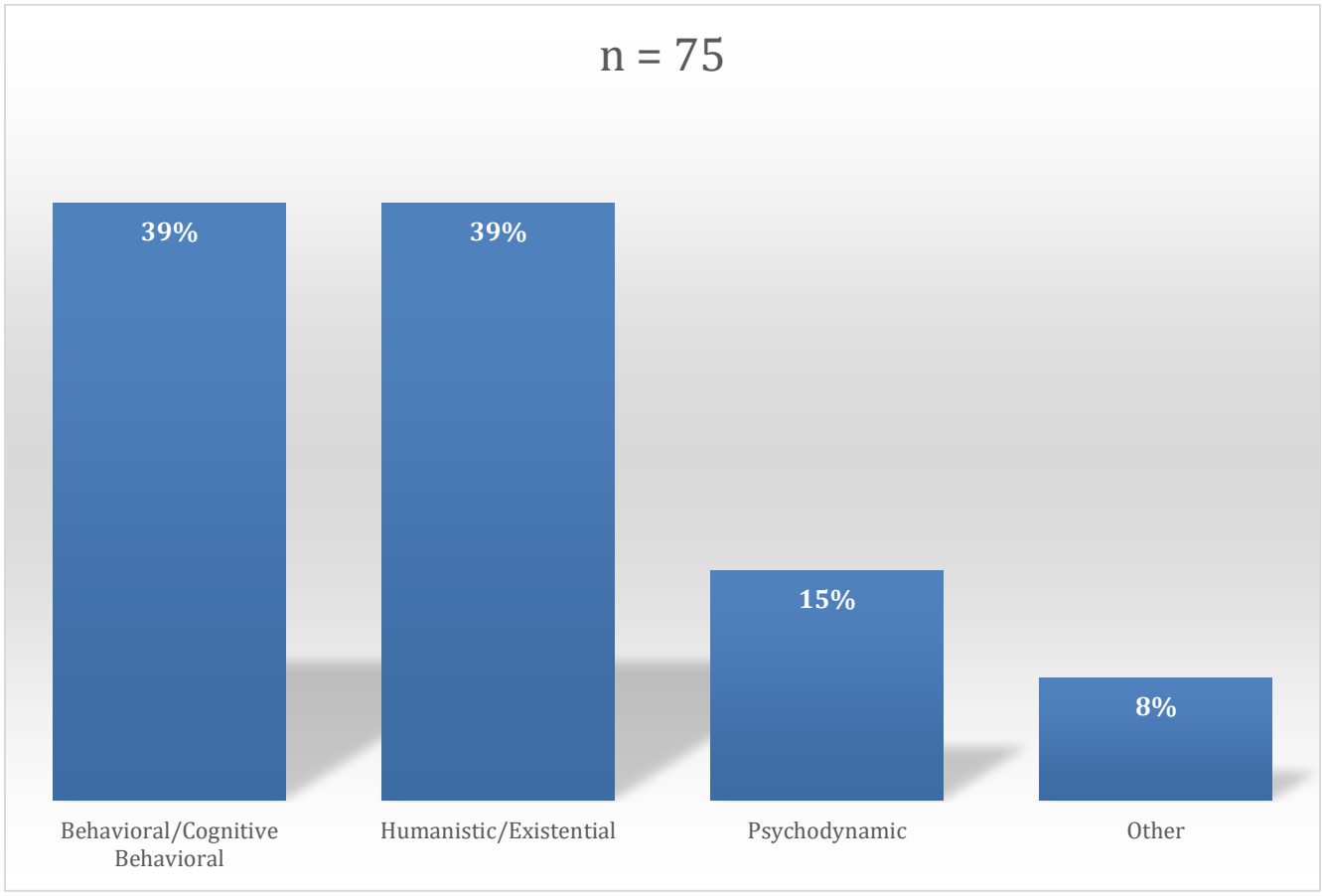
Analysis of survey responses focused on descriptive statistics for the overall sample and on the results broken out by theoretical orientation, as well as determining if there were statistically significant differences among orientations. In analyzing the differences between orientations, given the small sample sizes, particularly with respect to the psychodynamic orientation, Fisher's exact test was utilized, using an alpha of .05. Data were analyzed with the assistance of a statistician using the statistical program R, version 3.4.3.

Results

The survey results are provided in three sections: demographics, institution/working environment, and approaches/methods. For most of the survey questions, an overview of all respondents is provided as well as a breakout of results by theoretical orientation. Whether or not there was a statistically significant difference among theoretical orientations is noted. Besides analyzing differences among the orientations, responses that deviated from what could be expected from respondents, given their identified orientation, are also highlighted. In these instances, whether the respondents had a bachelor's or a master's degree is mentioned, with the underlying premise that a respondent with a master's has likely had greater training with respect to theoretical orientations and their underlying principles.

Figure 1 provides a breakout of the respondents' theoretical orientations. Those who responded as "other" described their orientation as either "combination," "dependent upon patient needs," "eclectic," "gestalt," or "humanistic, cognitive behavioral, mindfulness." Of those six respondents, four indicated that they have a bachelor's degree and two indicated a master's. When analyzing the results, because most respondents were able to choose among one of the three predesignated orientations, the "other" respondents were included in the overall results but were not included in the analysis of distinctions among theoretical orientations.

Figure 1 – Theoretical Orientation



Demographics

A breakout of respondents by their gender is provided in Figure 2. No respondents replied as "other." These results compare to Eyre and Lee's (2015) results for the broader field of mental health where 87% of respondents were female and 13% were male. When looking at the breakout by theoretical orientation, although the differences were not statistically significant, the percentage of female respondents was highest for the behavioral/cognitive behavioral category, followed by the psychodynamic category. The humanistic/existential orientation had the highest percentage of male respondents.

The age band with the largest number of overall respondents was the 30-39 years (see Figure 3). When looking at age, there was a statistically significant difference among theoretical orientations ($p = .011$). Comparing behavioral/cognitive behavioral and humanistic/existential, the former was weighted more heavily in the 50 and over age brackets while the latter was weighted more heavily in the under 30 age brackets. The psychodynamic respondents were spread more evenly across the various age brackets.

Figure 2 – Gender

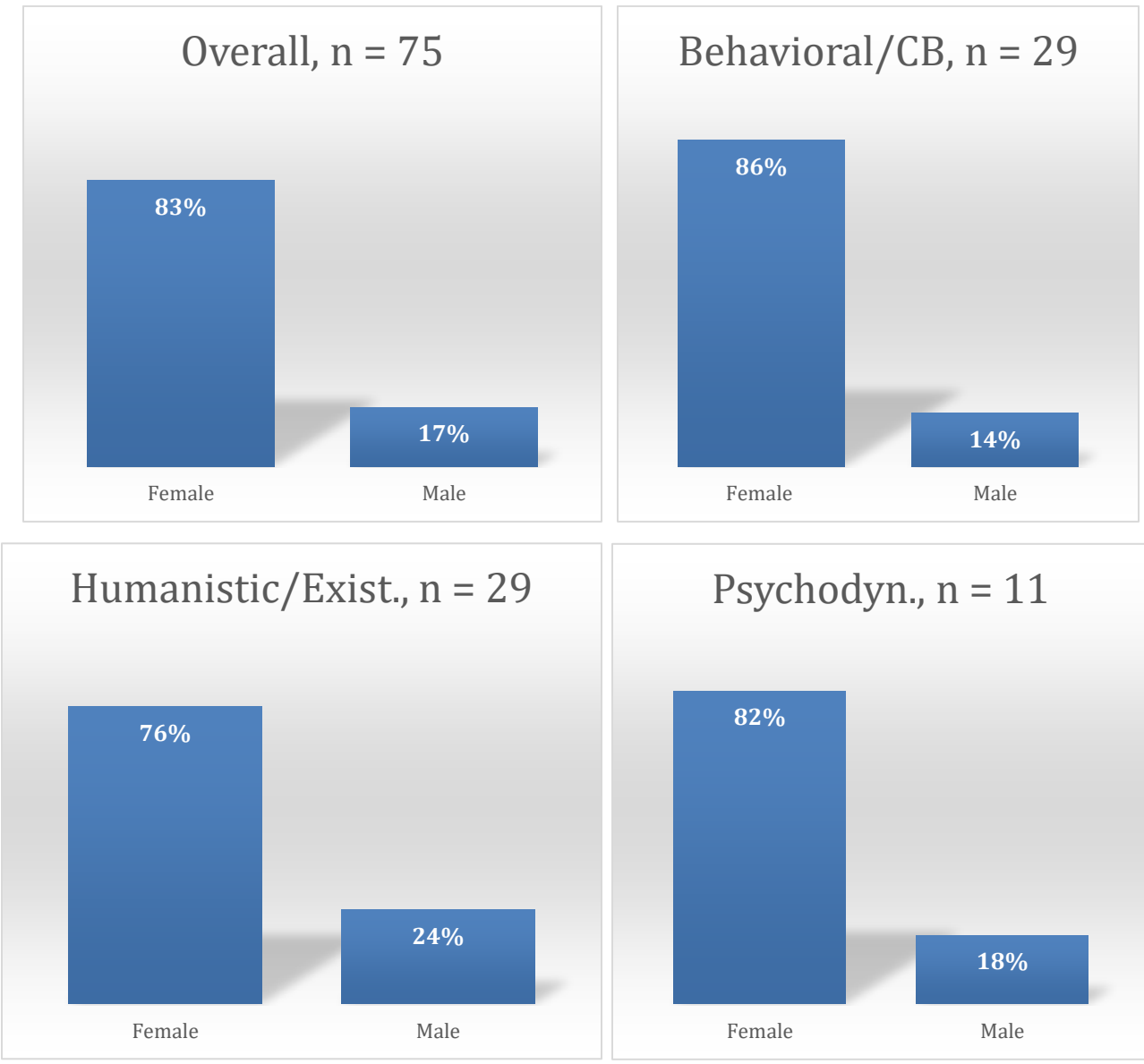
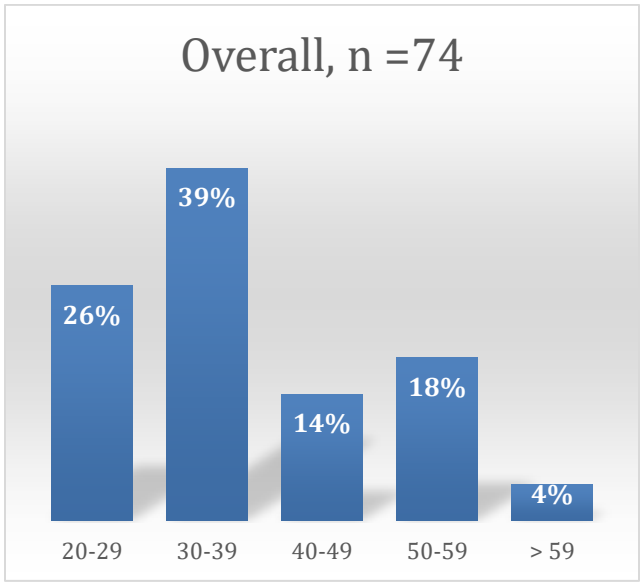
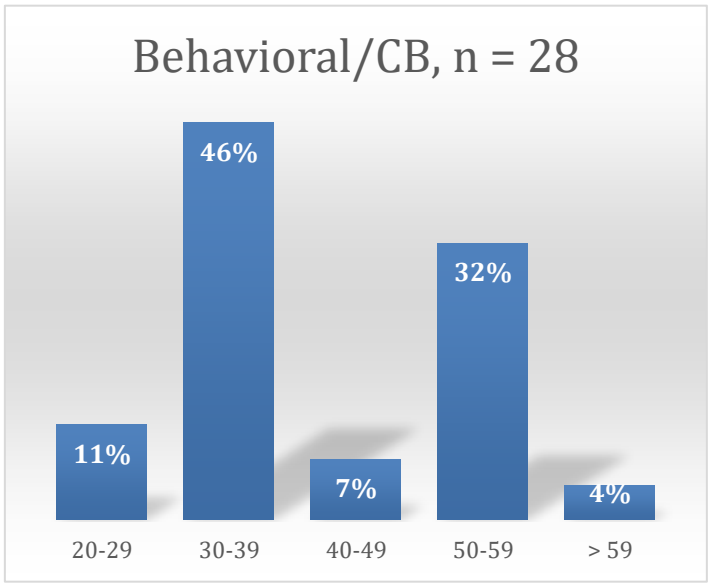
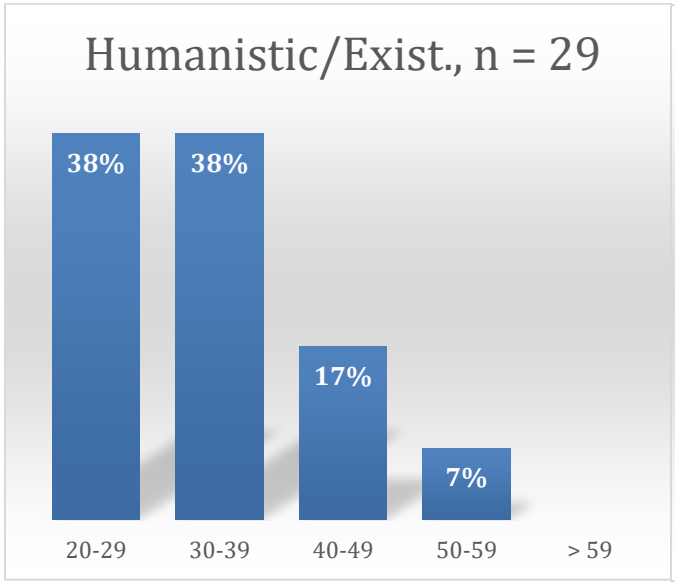
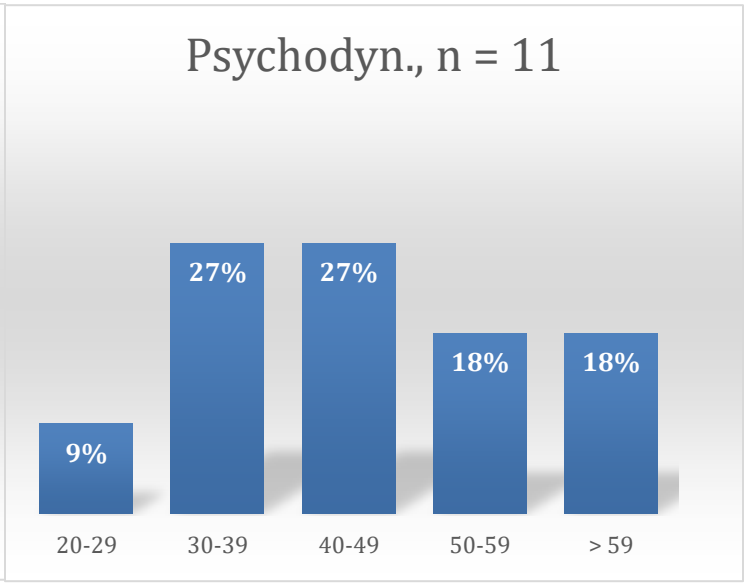


Figure 3 – Age


Overall, n =74
26%
39%
14%
18%
4%
20-29
30-39
40-49
50-59
> 59


Behavioral/CB, n = 28
11%
46%
7%
32%
4%
20-29
30-39
40-49
50-59
> 59

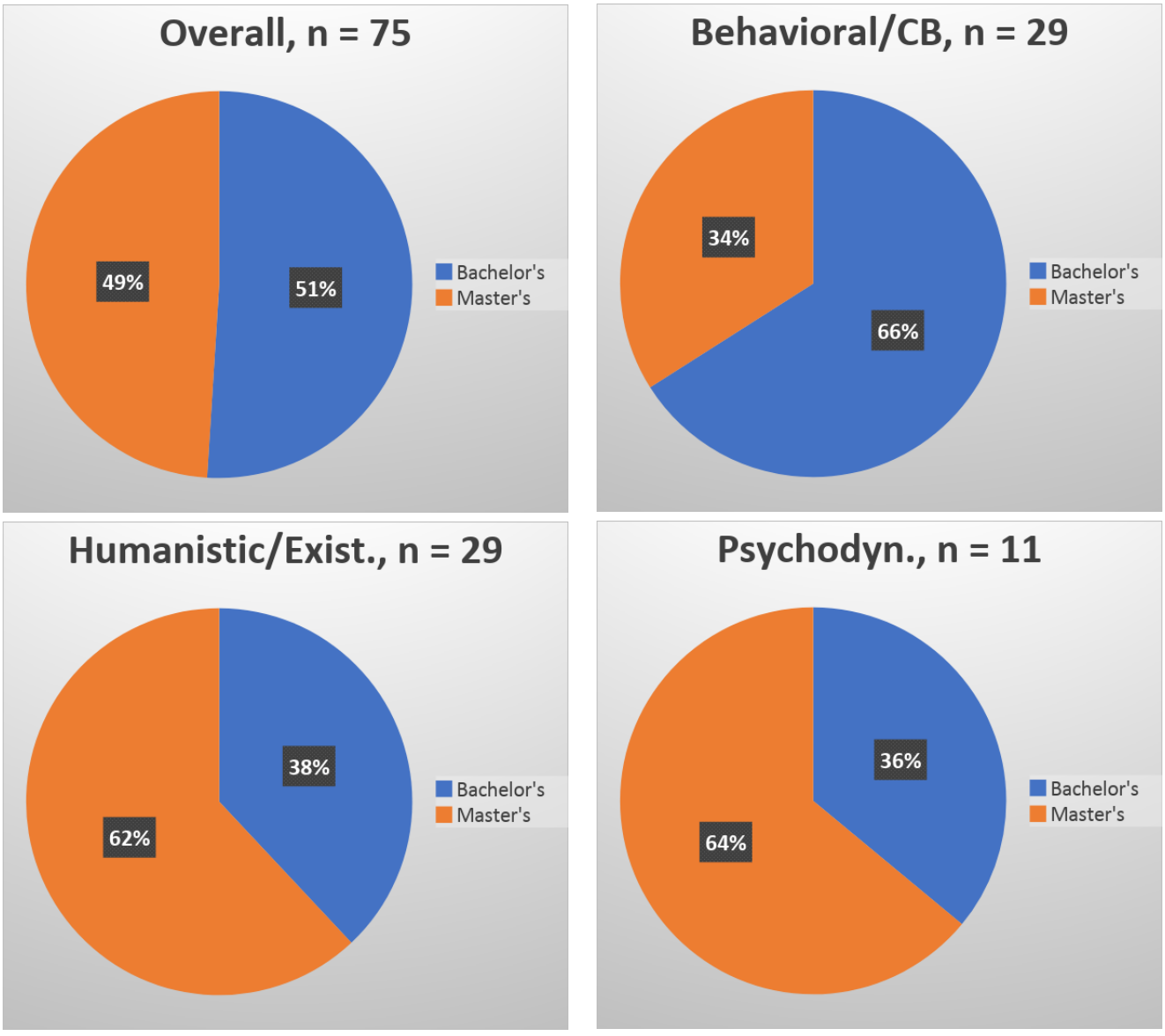

Humanistic/Exist., n = 29
38%
38%
17%
7%
20-29
30-39
40-49
50-59
> 59


Psychodyn., n = 11
9%
27%
27%
18%
18%
20-29
30-39
40-49
50-59
> 59

Overall respondents were nearly evenly split with respect to the highest level of music therapy related education attained, with a slight majority having a bachelor's degree (see Figure 4). No respondents had a doctorate. Eyre and Lee's (2015) results for the broad field of mental health showed 52% of respondents having a bachelor's, 43% having a master's, and 5% having a doctorate. The slight majority of overall respondents having a bachelor's degree is largely due to the sizable percentage of behavioral/cognitive behavioral respondents having a bachelor's. By comparison, a majority of both humanistic/existential and psychodynamic respondents had a master's. Any differences among theoretical orientations were not statistically significant.

Respondents earned their respective music therapy degrees from 43 colleges and universities dispersed across the US. The schools that graduated the highest number of respondents were New York University (5 respondents), Drexel University (4), Temple University (4), and University of Missouri, Kansas City (4). All Drexel and New York University respondents identified as having either humanistic/existential or psychodynamic orientations, and all of the Temple respondents identified as humanistic/existential. Conversely, all but one of the University of Missouri, Kansas City respondents identified as having a behavioral/cognitive behavioral orientation.

Figure 4 – Highest Level of Music Therapy Education



Most respondents (66%) have worked in an ACAPF for between 1-10 years (see Figure 5), with 11% having more than 20 years of experience. This compares with the results of Eyre and Lee's (2015) study showing 59% of respondents having 1-10 years of experience and 22% having more than 20 years of experience. When looking at the breakout between theoretical orientations, humanistic/existential respondents had the highest percentage with 5 years or less experience, psychodynamic respondents had the highest percentage with 6-20 years of experience, and behavioral/cognitive behavioral respondents had the highest percentage with more than 20 years of experience. Any differences among orientations did not prove to be statistically significant.

Respondents were reasonably well dispersed among the seven AMTA geographic regions (see Figure 6), with the largest number of respondents being from the Mid-Atlantic region. Only one respondent came from the New England region. With respect to the theoretical orientations of respondents within the regions, respondents from the Great Lakes region identified primarily as humanistic/existential (43%) and behavioral/cognitive behavioral (36%). Respondents from the Mid-Atlantic region identified primarily as humanistic/existential (58%) and psychodynamic (29%). Southeastern region respondents primarily identified as behavioral/cognitive behavioral (56%) and humanistic/existential (33%). All respondents from the Midwestern and Southwestern regions identified as either behavioral/cognitive behavioral (75% and 83%, respectively) or humanistic/existential (25% and 17%, respectively). The one respondent from the New England region identified as being behavioral/cognitive behavioral, and the respondents from the Western region were evenly divided between behavioral/cognitive behavioral and humanistic/existential orientations. Approximately 77% of overall respondents indicated that

Figure 5 – Years of ACAPF Work Experience

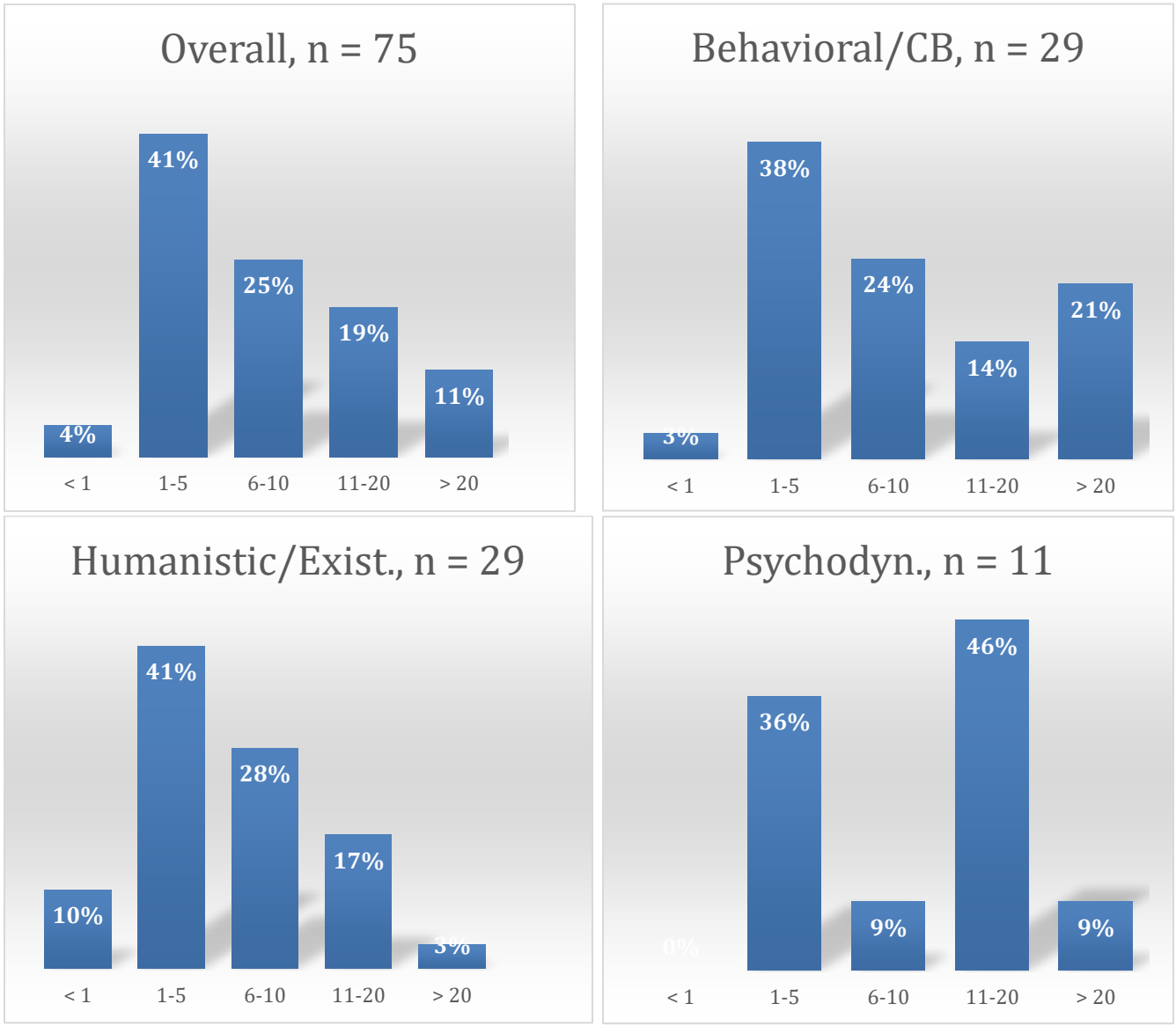
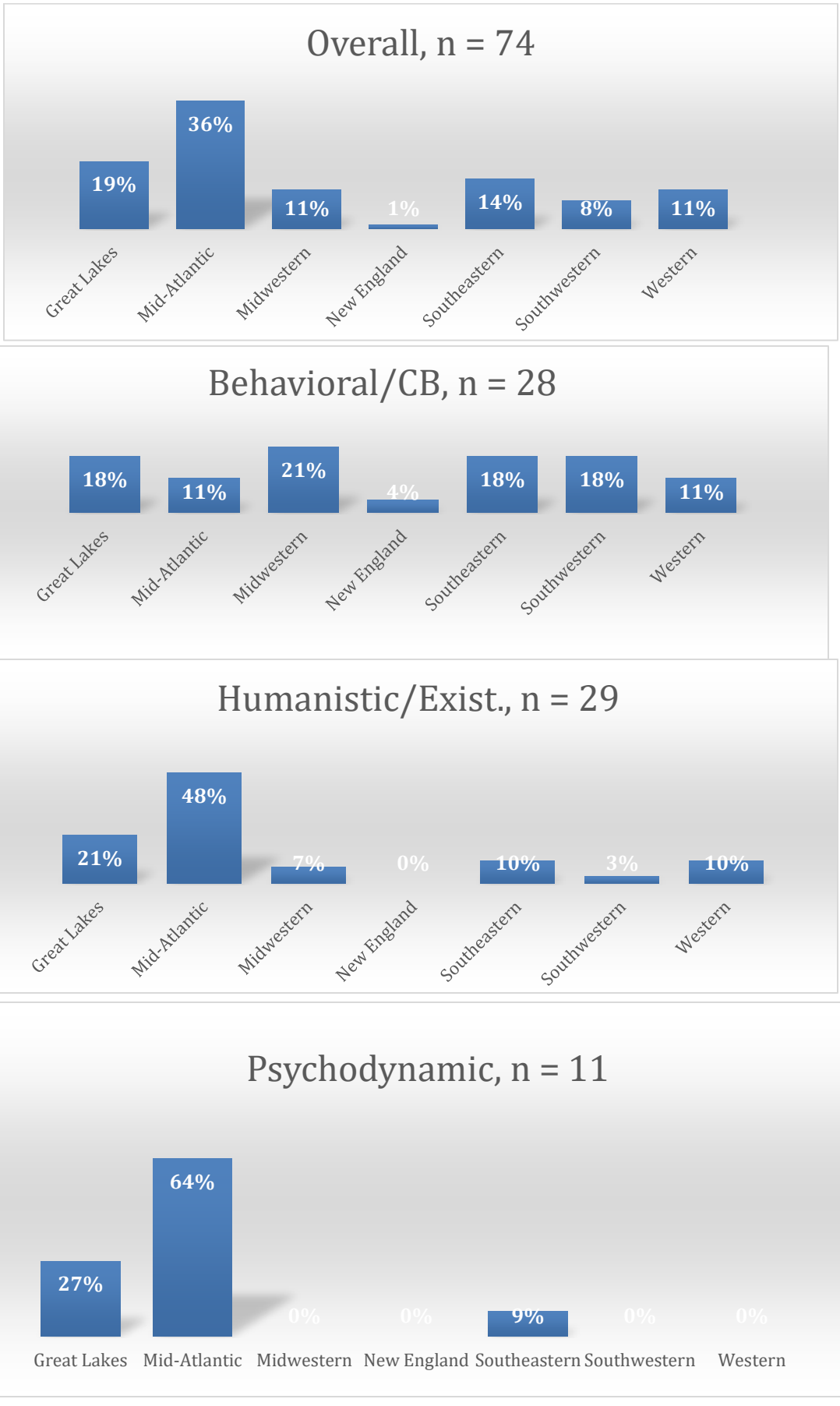


Figure 6 – Respondent Dispersion Among AMTA Geographic Regions



their ACAPF was in a major metropolitan area; this finding did not vary significantly among orientations.

Institution/Working Environment

Approximately 65% of overall respondents worked at least 30 hours per week (see Figure 7), and most respondents worked on from two to five units (see Figure 8) at their ACAPF. The percentages for both measurements did not vary significantly among the different theoretical orientations. In Eyre and Lee's (2015) study, approximately 64% of the respondents worked more than 30 hours per week.

The survey results show that most (88%) respondents worked on units that housed from 10-30 patients (see Figure 9). With this parameter, there was a statistically significant difference (p = .003) among theoretical orientations. Behavioral/cognitive behavioral respondents tended to work on smaller units with 20 or fewer patients, humanistic/existential respondents worked on more moderate sized units with 10-30 patients, and psychodynamic respondents worked on larger units with at least 20 patients.

Figure 7 – Weekly Hours

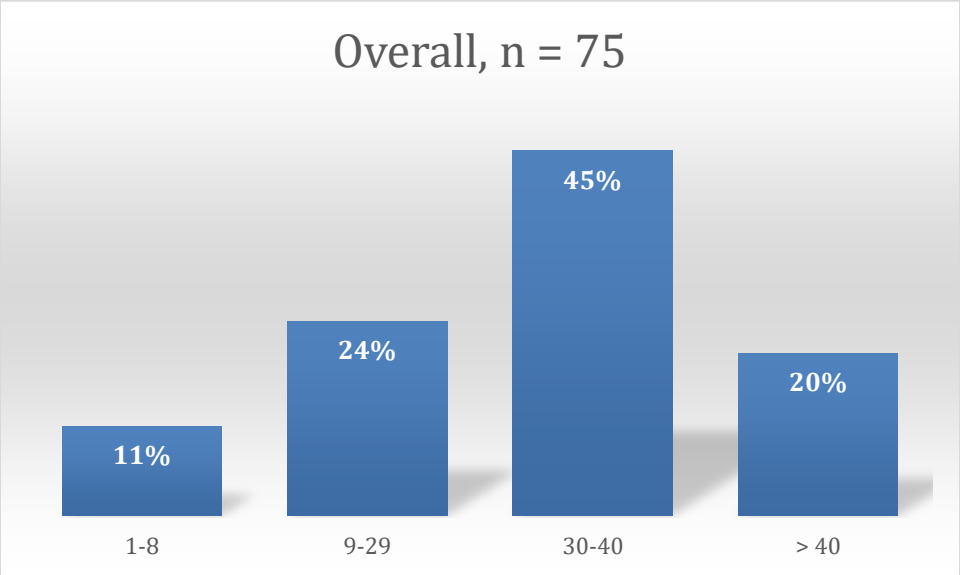


Figure 8 – Number of Units Serviced

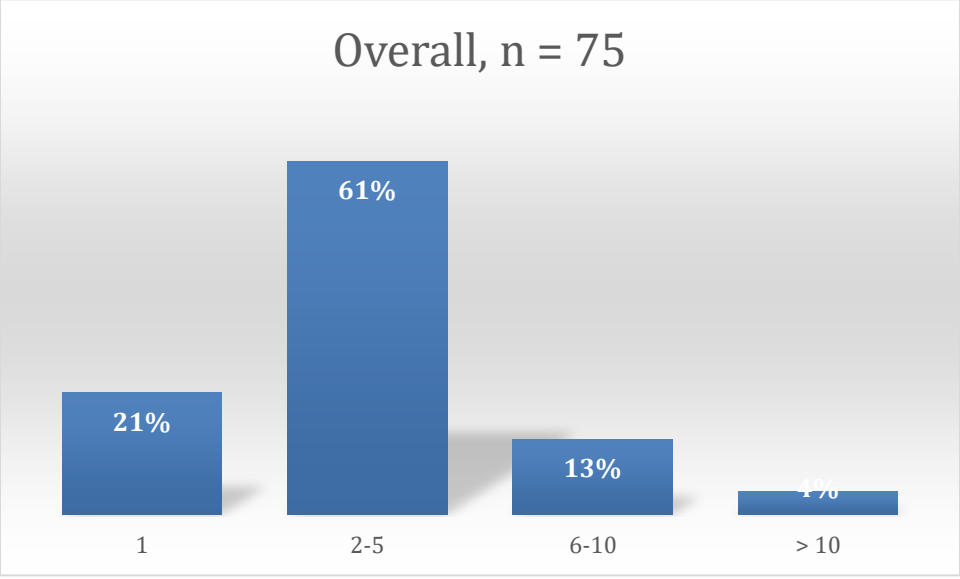
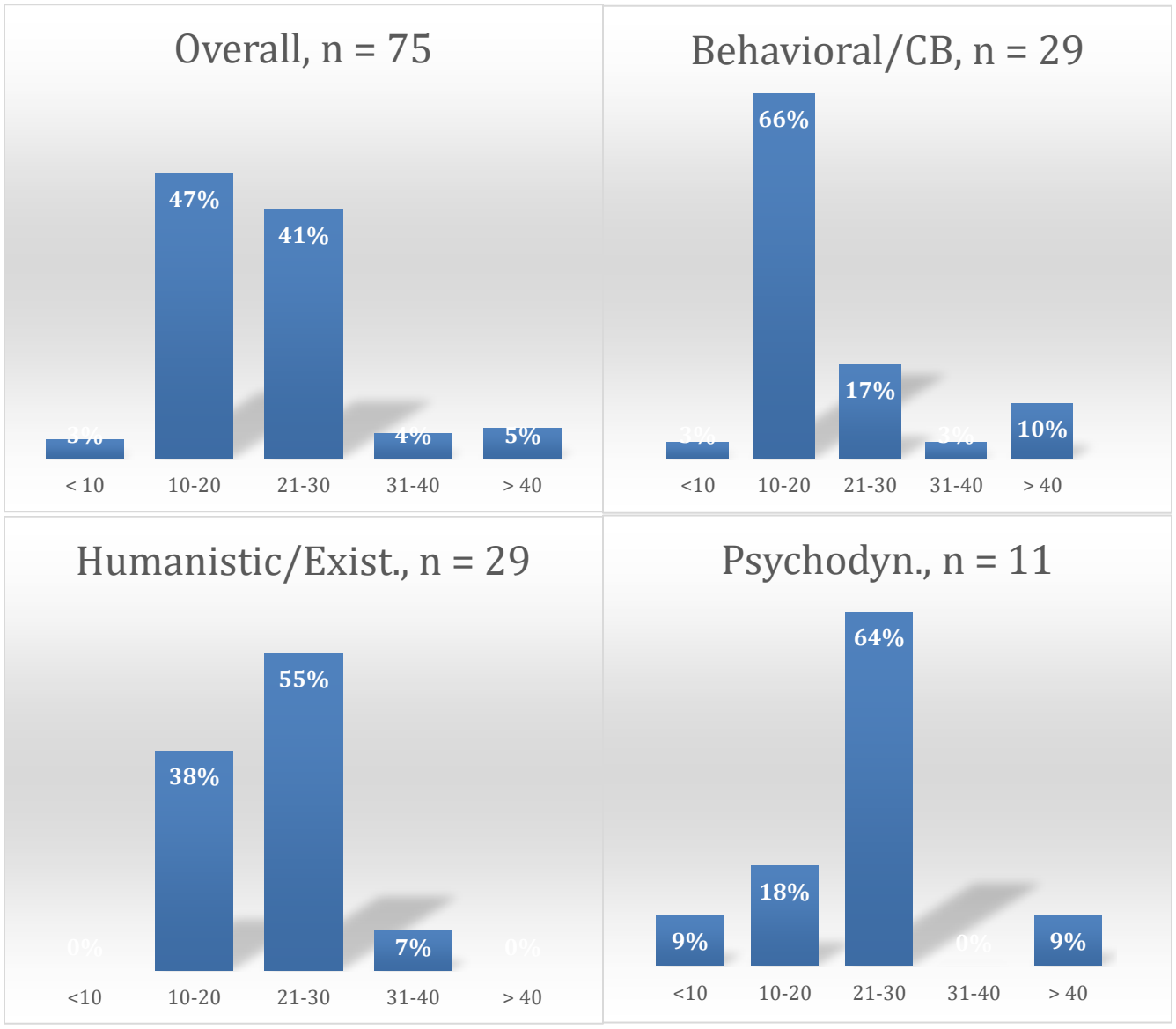


Figure 9 – Average Number of Patients per Unit



Respondents overall indicated the typical length of stay for their patients was between 1-2 weeks (see Figure 10). Within this parameter there was also a statistically significant difference (p = .002) among theoretical orientations. The typical length of stay indicated by behavioral/cognitive behavioral respondents was relatively shorter than the other two orientations, with the majority reporting a typical length of stay of only 3-7 days.

The greatest number of overall respondents reported 3-5 times per week as the frequency with which music therapy groups were offered to their patients (see Figure 11), and there was no significant difference among theoretical orientations. Respondents overall reported that the majority of their sessions were conducted as groups rather than individual sessions (see Figure 12). Although not statistically significant, there was a difference among theoretical orientations for this parameter, with the mean for behavioral/cognitive behavioral respondents indicating that 13% of their sessions were conducted on an individual basis, while the comparable percentage for both humanistic/existential and psychodynamic respondents was only 4%.

With respect to the number of daily sessions conducted by respondents overall, the mean number of daily groups was 2.68 (SD = 1.24). There was not a statistically significant difference among theoretical orientations, with the mean for behavioral/cognitive behavioral respondents being 2.48 (SD = 1.33), and for humanistic/existential and psychodynamic respondents being 2.90 (SD = 1.11) and 2.64 (SD = 1.36), respectively. For respondents overall, the mean for the number of daily individual sessions was .57 (SD = 1.00). Regarding the duration of group sessions, overall responses ranged from 40-75 minutes, with a mean duration of 53 (SD = 7.24) minutes. There were no statistically significant differences among orientations.

Figure 10 – Typical Length of Stay (Days)

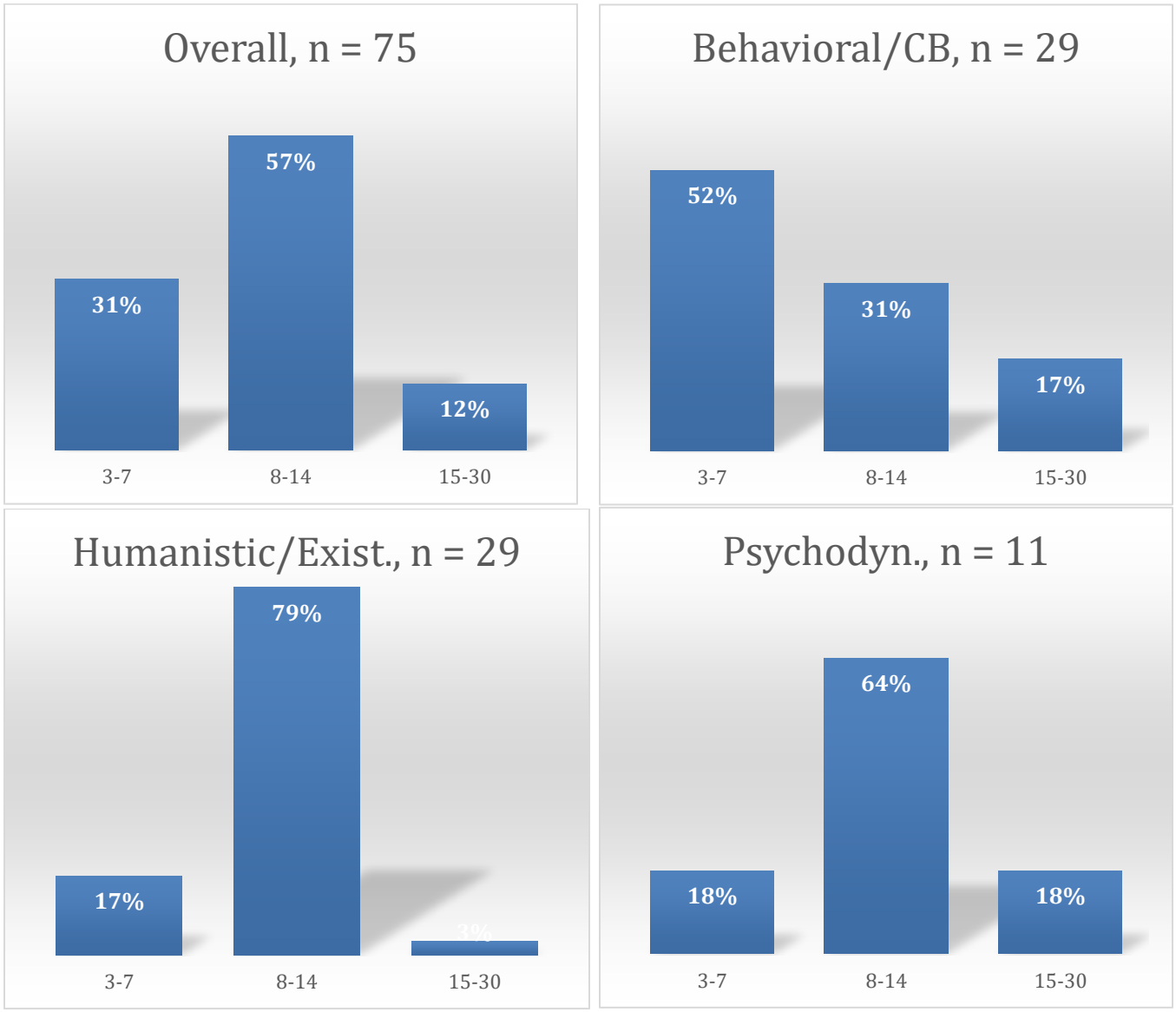


Figure 11 – Number of Weekly Music Therapy Groups

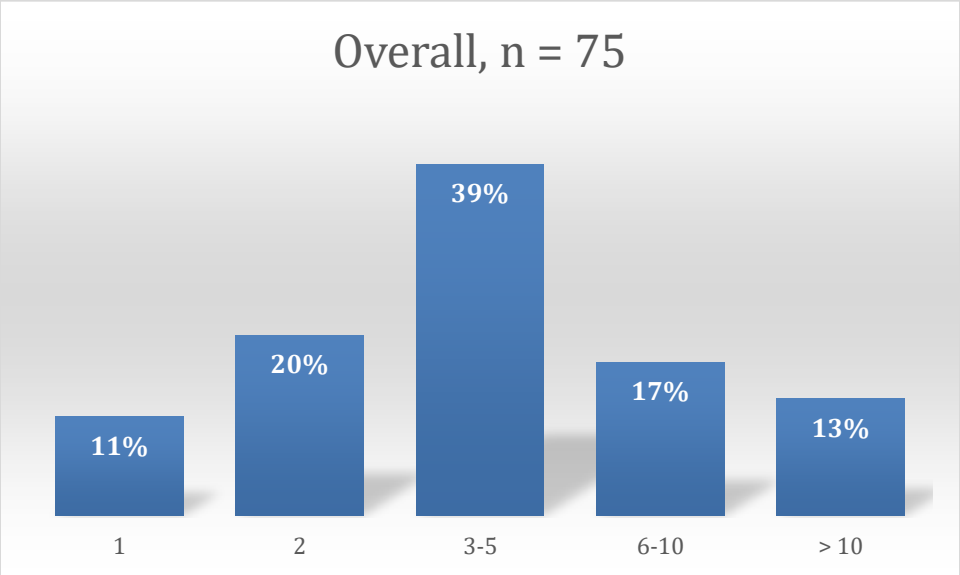
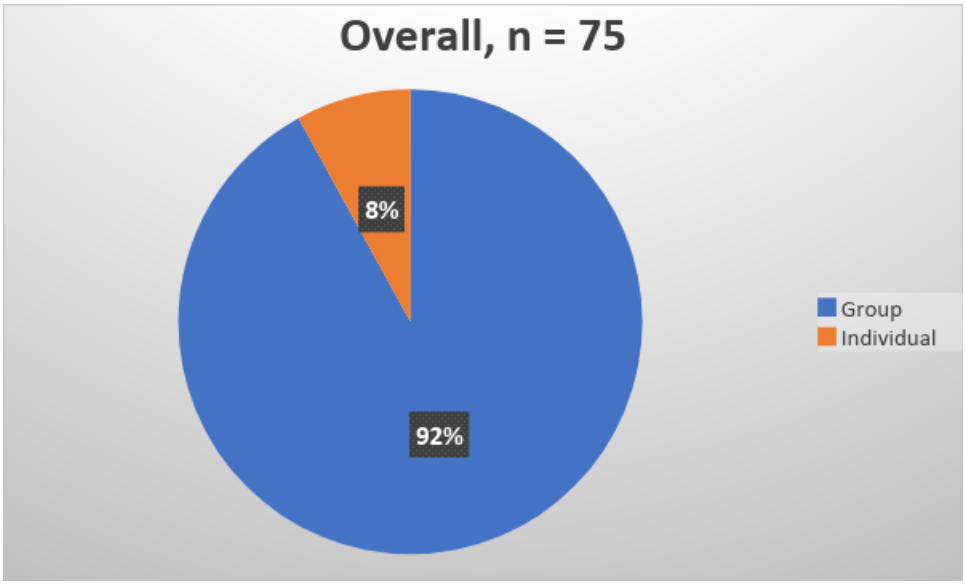


Figure 12 – Percentage of Group/Individual Sessions



The results showed that most groups conducted in ACAPFs had from 6-10 members (see Figure 13). Although the differences among theoretical orientations were not statistically significant, groups conducted by behavioral/cognitive behavioral respondents tended to be smaller, with 76% reporting a typical group size of 10 members or less, whereas 58% of humanistic/existential respondents and 64% of psychodynamic respondents indicated typical group sizes within that range.

Overall results indicated that most groups conducted in ACAPFs were held in an enclosed room, either a specifically designated music therapy/creative arts room or some other type of enclosed room (see Figure 14). When analyzing this parameter with respect to theoretical orientation, although the differences were not statistically significant, humanistic/existential respondents reported the highest percentage of groups conducted in an open dayroom, while psychodynamic respondents had the lowest percentage of groups held in such dayrooms and the highest percentage of groups held in designated music therapy/creative arts rooms.

Nearly all (93%) respondents indicated that they are able to work in their ACAPF in a manner consistent with their theoretical orientation. Of the five respondents who indicated they did not work in a manner consistent with their orientation, four identified as being humanistic/existential and explained that their ACAPF has an underlying philosophy more consistent with a behavioral/cognitive behavioral orientation. The fifth respondent indicated his or her orientation as behavioral/cognitive behavioral and provided the explanation that the ACAPF has no designated orientation.

Figure 13 – Typical Number of Group Members

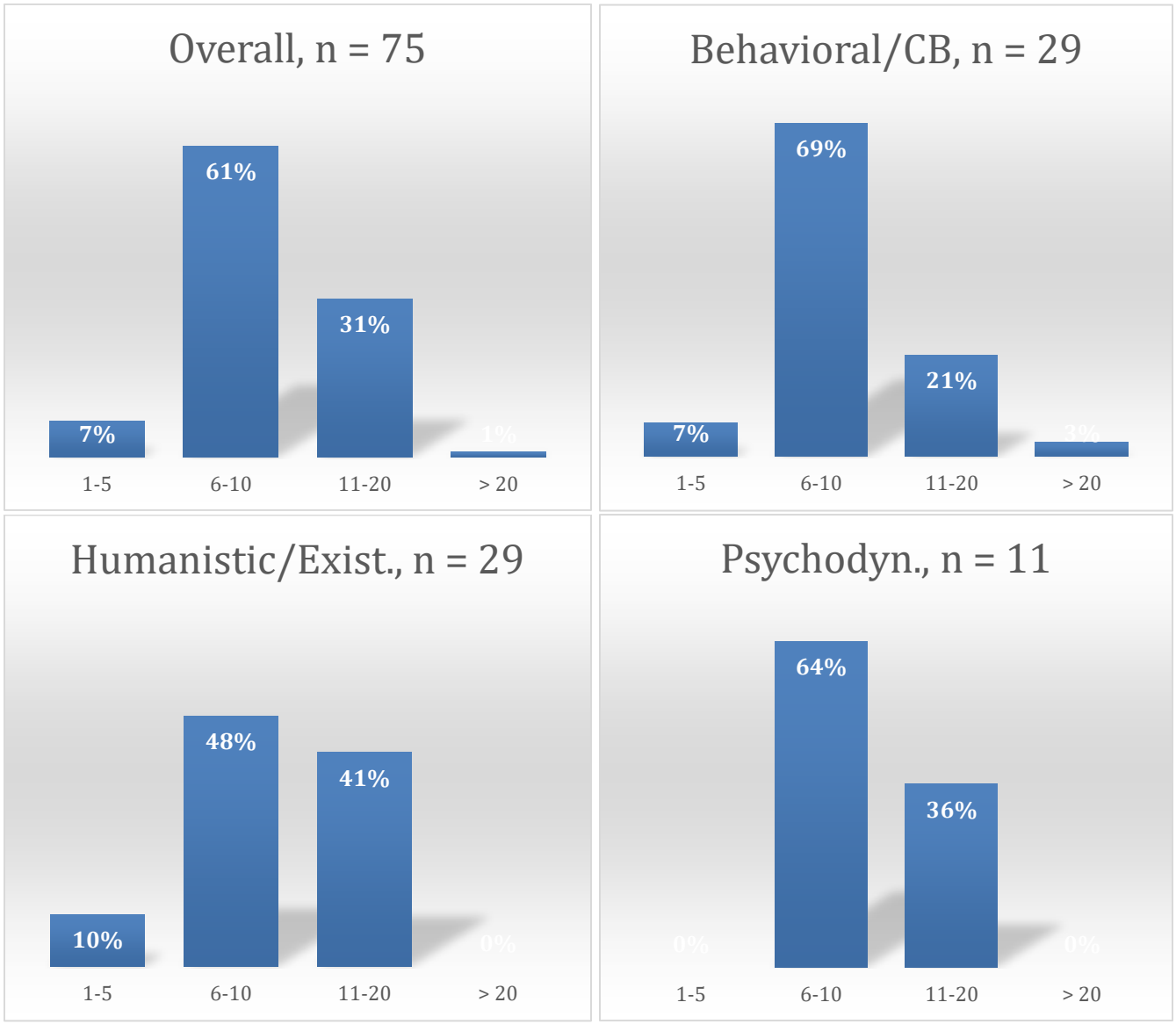
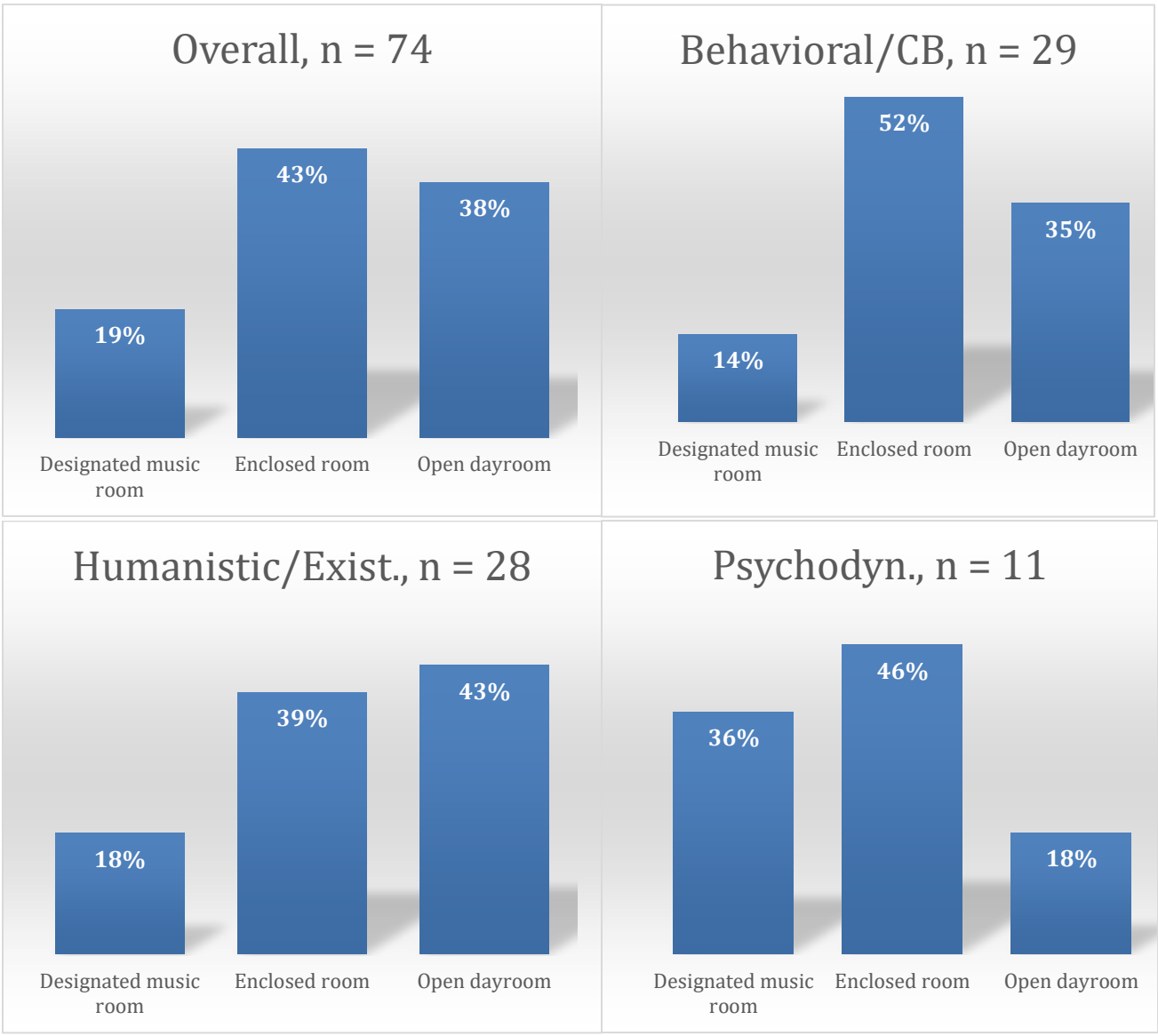


Figure 14 – Group Site



Approaches/Methods

Respondents overall were almost evenly split with respect to whether they use music *as* therapy or *in* therapy, with a small number being unsure (see Figure 15). All but one of the unsure respondents held a bachelor's degree. Although the results were not statistically significant, most behavioral/cognitive behavioral respondents indicated that they use music *in* therapy, while most humanistic/existential and psychodynamic respondents reported they use music *as* therapy.

Most respondents indicated that they use a moderate amount of structure in their group sessions (see Figure 16), and there were no statistically significant differences among orientations. Interestingly, two of the behavioral/cognitive behavioral respondents considered their group sessions to be "not very structured."

Most respondents replied that, prior to a session, they developed a plan of interventions/experientials to be used during the session (see Figure 17). Although the results were not statistically significant, a higher percentage of behavioral/cognitive behavioral respondents indicated the development of a session plan than did the humanistic/existential and psychodynamic respondents. Of those respondents who did develop a session plan, the majority indicated that they were not necessarily committed to executing the predetermined plan once the session was underway. However, although again the differences among theoretical orientations were not statistically significant, 24% of behavioral/cognitive behavioral respondents indicated that they were committed to executing the predetermined plan, compared to 14% for both humanistic/existential and psychodynamic respondents.

Figure 15 – Music *as* or *in* Therapy

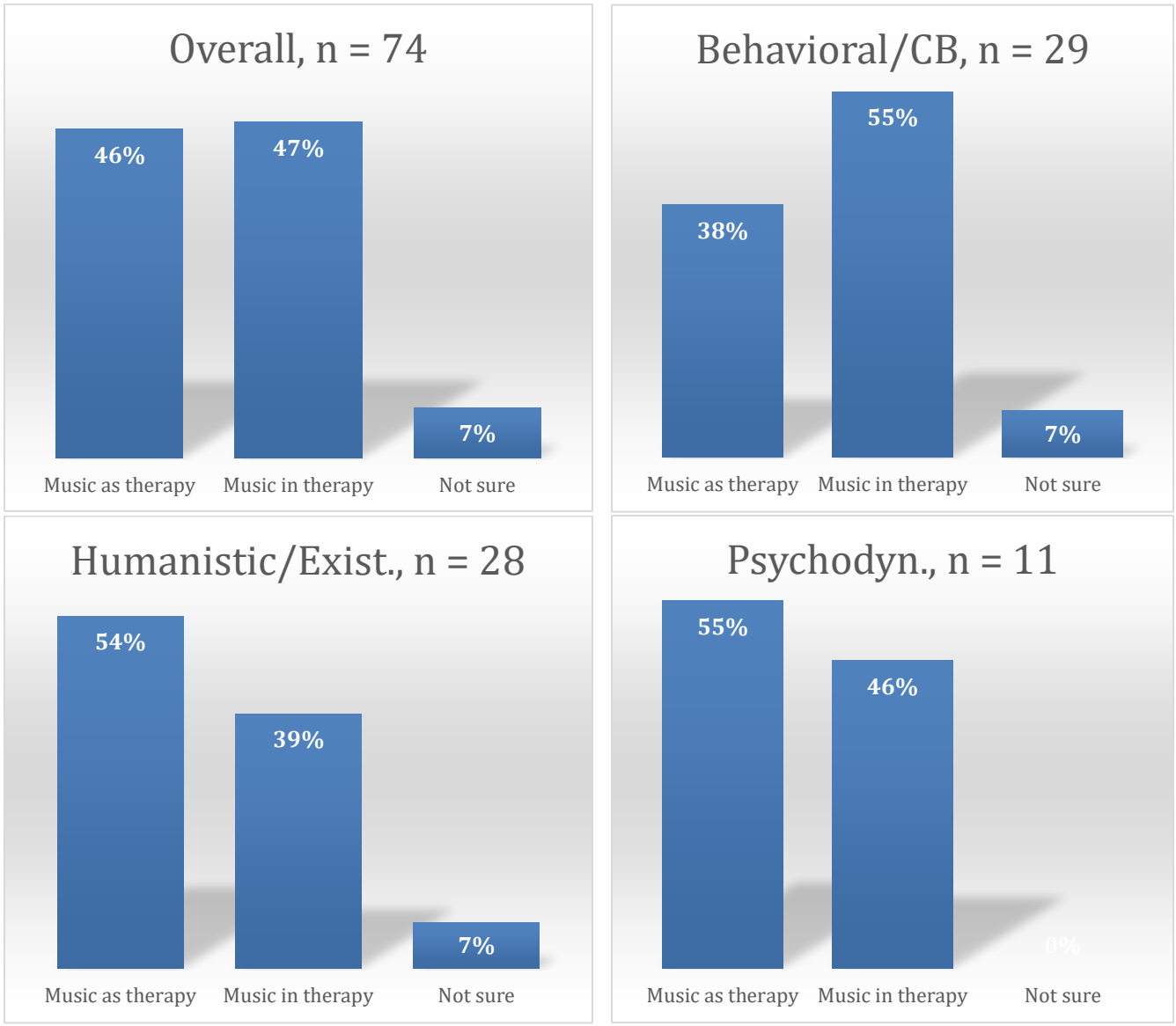


Figure 16 – Degree of Group Session Structure

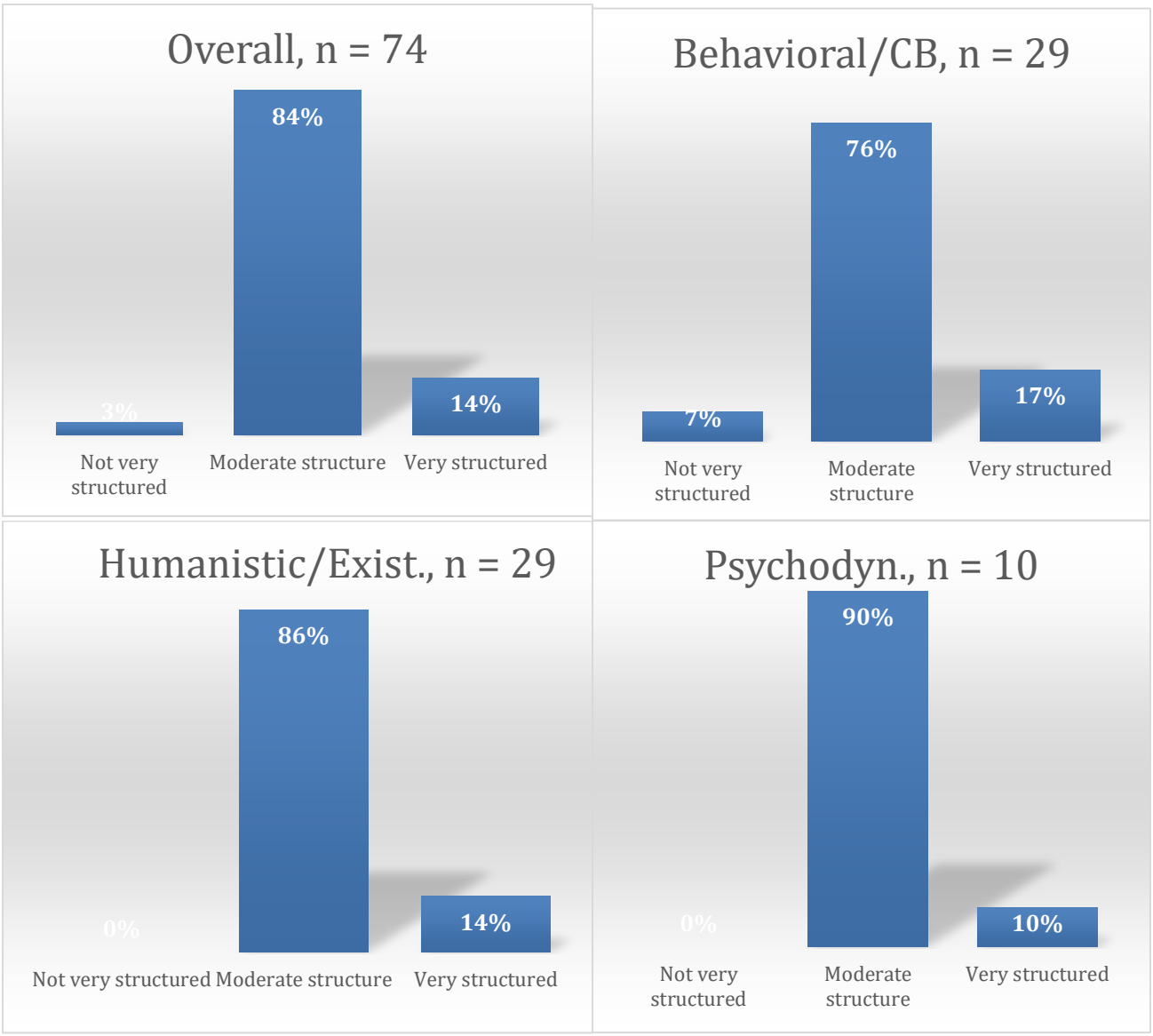
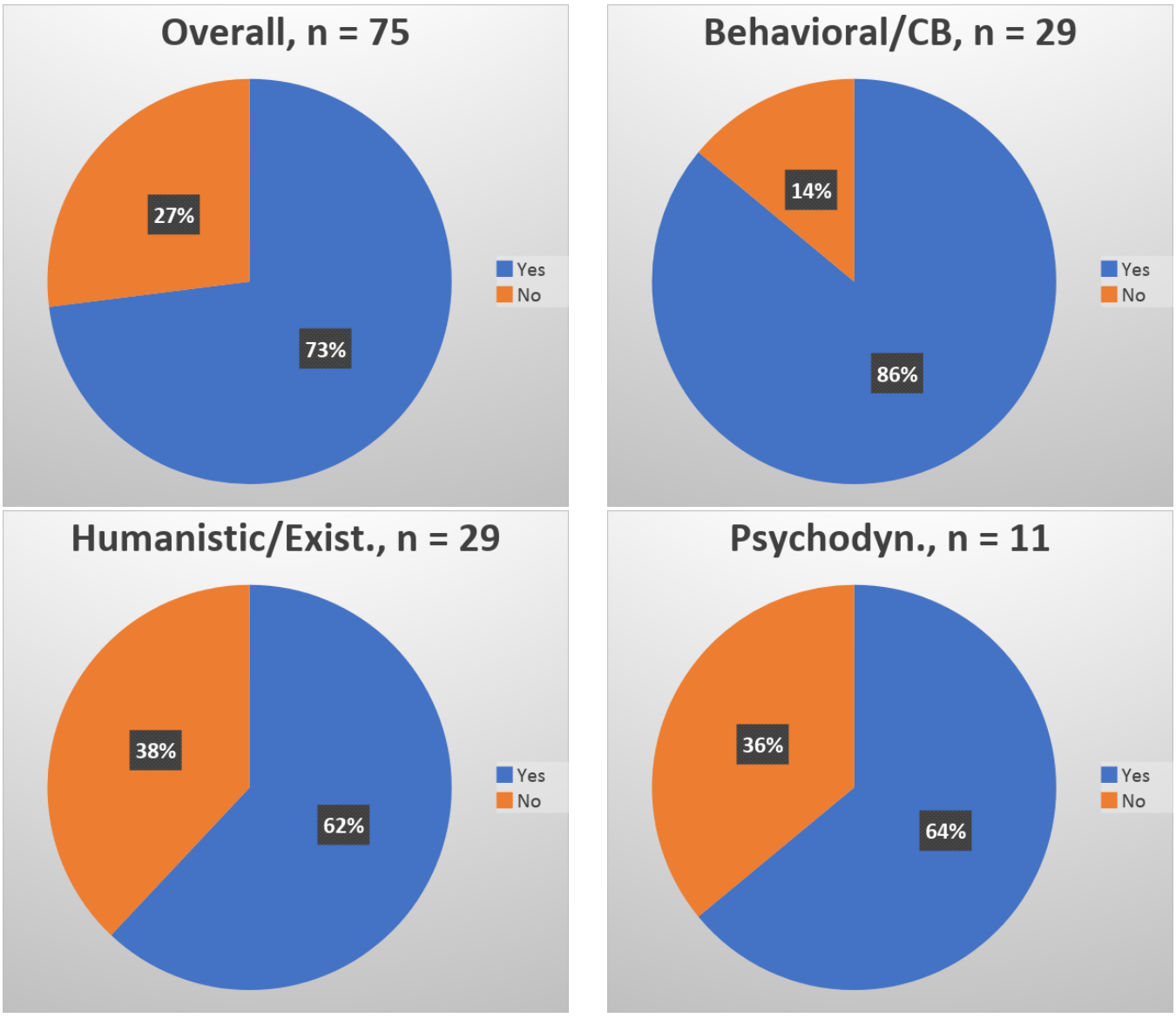


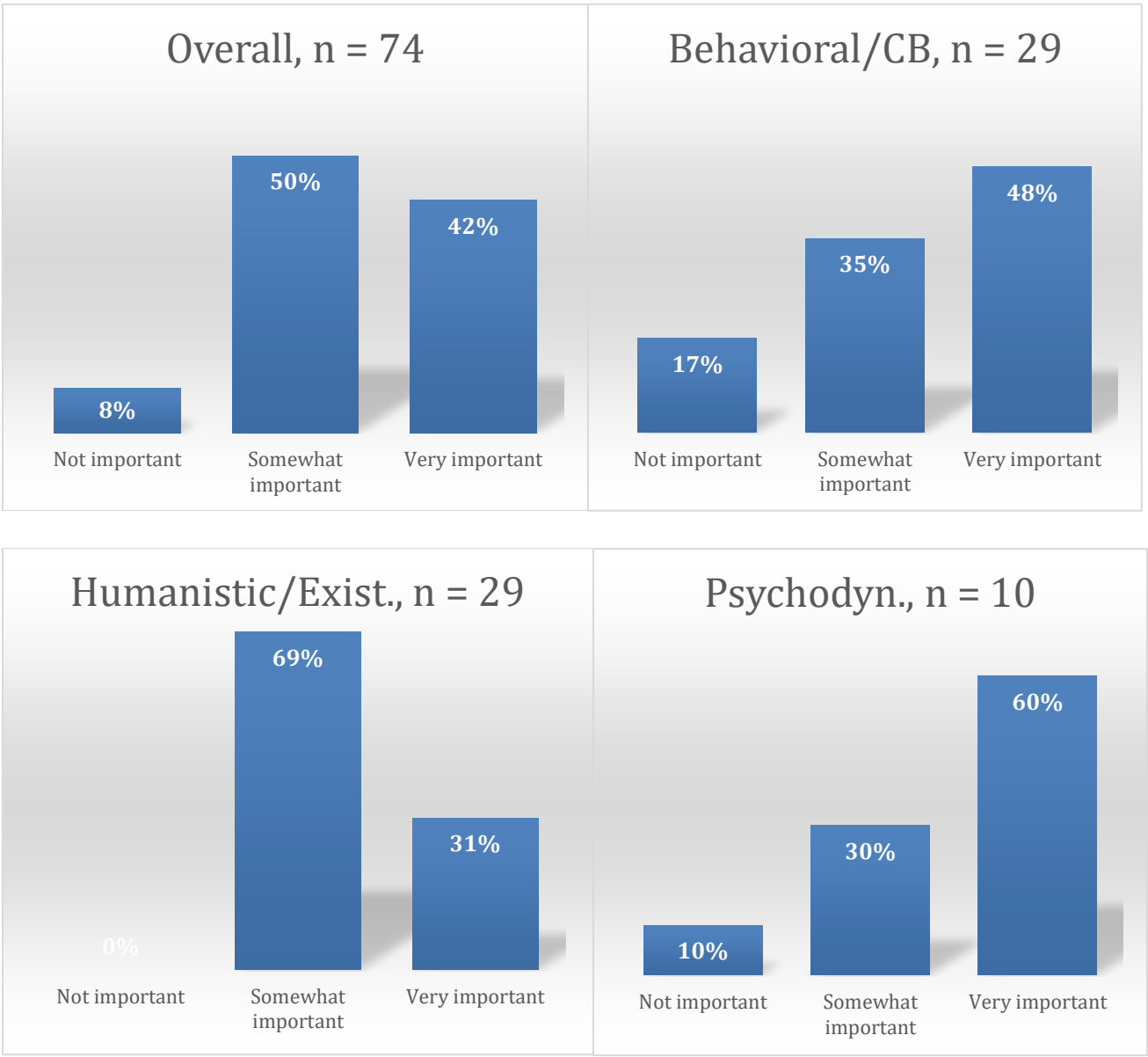
Figure 17 – Group Session Plan



Of the respondents overall, 80% indicated that when a group session was underway, they considered "to a great extent" the group members and their presenting mental conditions in determining the particular interventions/experientials to be used in that session. Although there were no statistically significant differences among orientations, 83% of humanistic/existential respondents reported "to a great extent" for this parameter, compared to 82% for psychodynamic respondents and 76% for behavioral/cognitive behavioral respondents. Interestingly, one behavioral/cognitive behavioral respondent indicated that he or she did not take into consideration at all the presenting mental conditions of group members when determining the interventions/experientials to be used once a session was underway.

Half of all respondents reported the importance to them of group members' musical experiences being generalizable to settings outside of a musical setting as "somewhat important" (see Figure 18). For this measurement, there was a statistically significant difference ($p = .016$) among theoretical orientations, with the psychodynamic respondents having the highest percentage to indicate "very important" and the behavioral/cognitive behavioral respondents having the highest percentage indicating "not important."

Figure 18 – Importance of Generalizability of Group Members' Musical Experiences



All respondents indicated the importance to them of their group members gaining some degree of insight into their mental condition as either "somewhat important" or "very important" (see Figure 19). Here again, differences among theoretical orientations were statistically significant (p = .001), with more than 75% of both behavioral/cognitive behavioral and psychodynamic respondents scoring this parameter as "very important," and 69% of humanistic/existential respondents scoring it as only "somewhat important." Most respondents reported that group members feeling like they had participated in a creative process was "very important" (see Figure 20). Although the differences among theoretical orientations were not statistically significant, humanistic/existential respondents had the highest percentage that marked this as "very important," while the behavioral/cognitive behavioral respondents had the lowest percentage that marked it as "very important."

Respondents who did not reply "very important" to any of the three survey questions discussed in the preceding paragraph were asked to describe their main priority for group members. Of the five eligible respondents who answered, three identified as humanistic/existential, and their responses were: "To provide reality orientation, an opportunity to socialize, and assess behaviors for further treatment recommendations"; "To identify and obtain something that is helpful to them"; and "Depending on my groups and the acuity of the current patients, my main goals are participation and mood stabilization/relaxation." One respondent, who identified as being psychodynamic, answered, "Experiencing live music, actively participating in making music, recognizing what they can do regardless of diagnosis, etc." One respondent, who identified as being behavioral/cognitive behavioral, replied, "Sometimes the patients are very sick and it's enough for them to just get there."

Figure 19 – Importance of Insight for Group Members

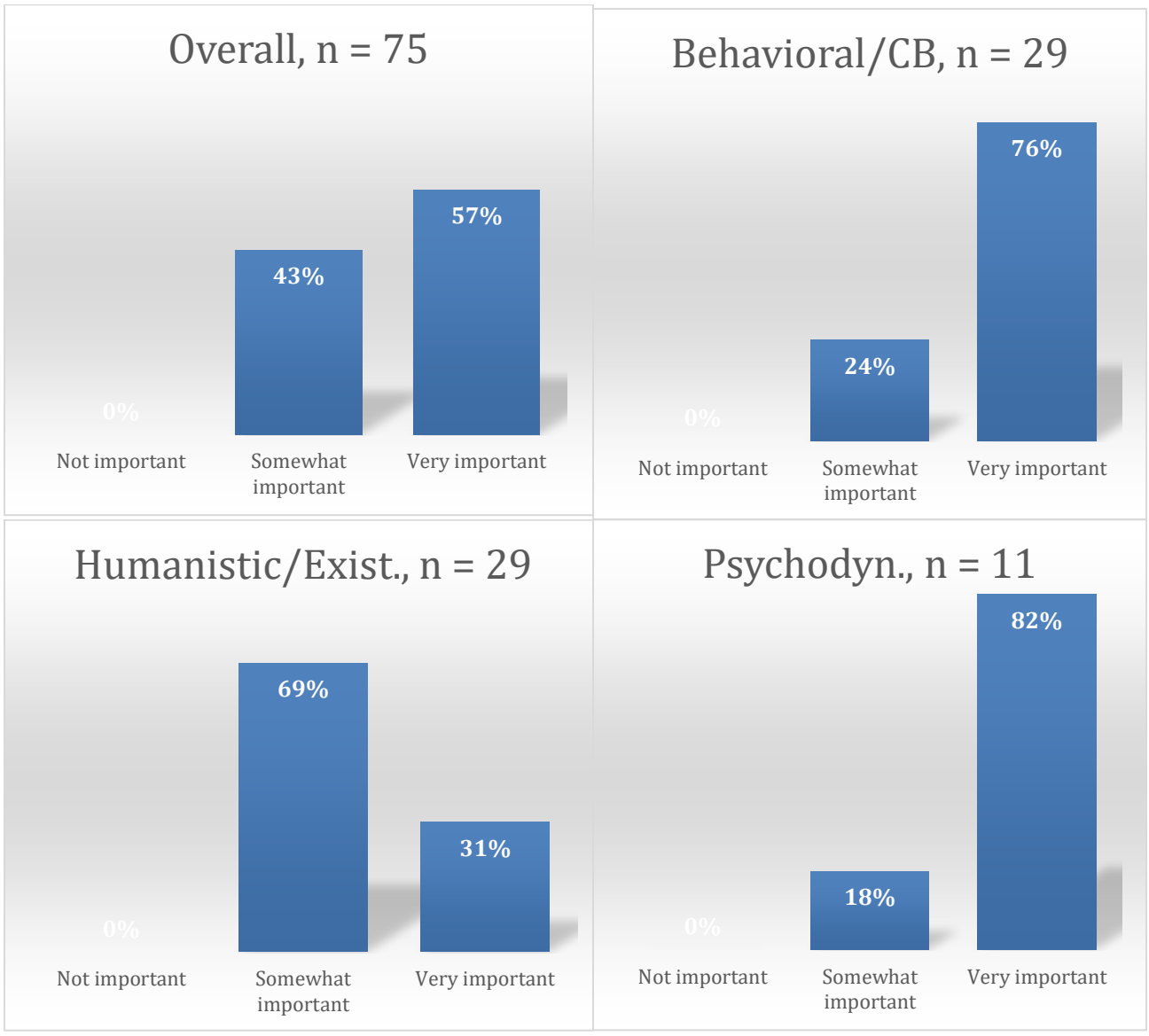


Figure 20 – Importance of Group Members Feeling Creative

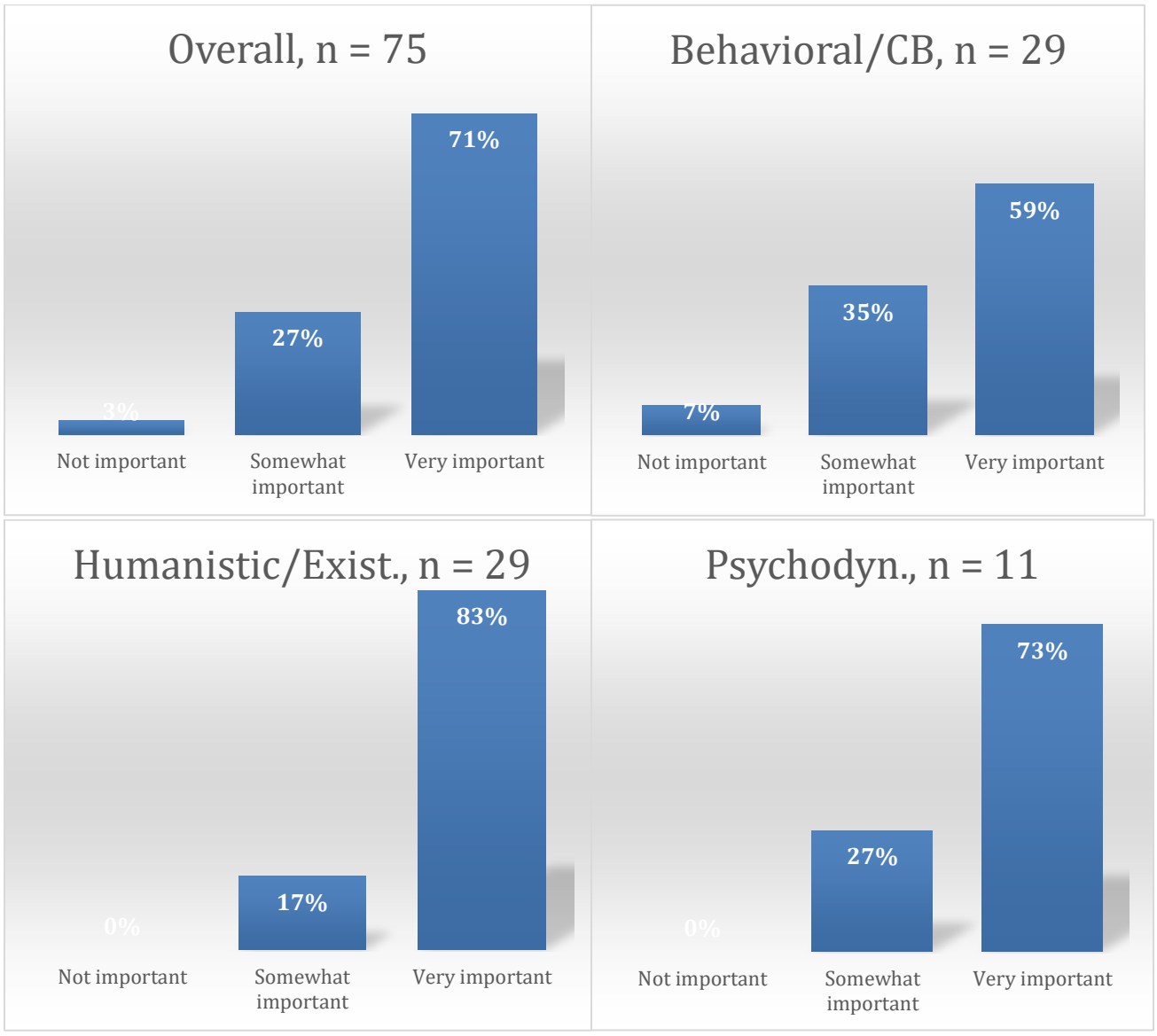
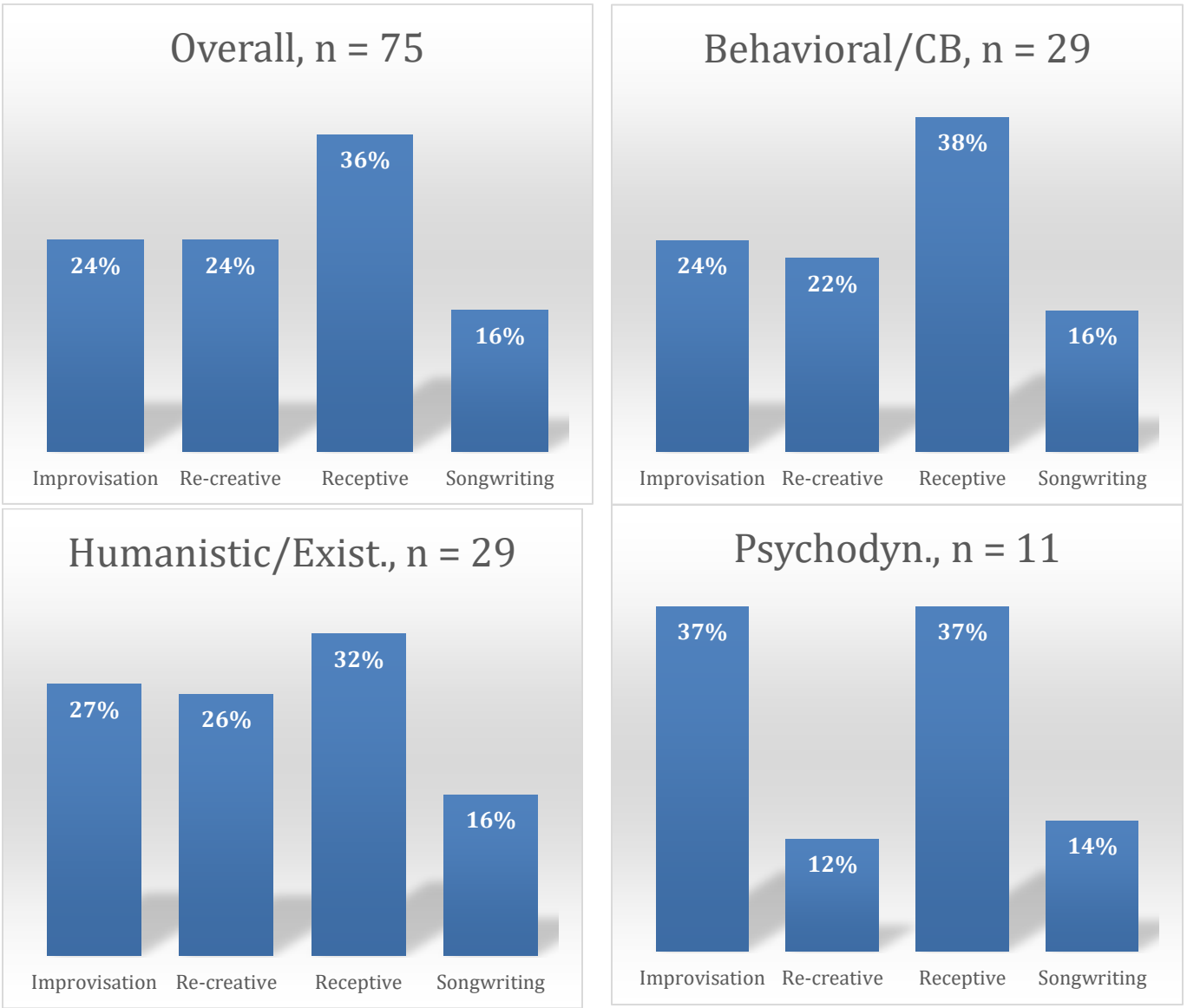


Figure 21 provides a breakout of the main methods used by respondents overall, as well as a breakout of the main methods used by the different theoretical orientations. Bruscia's (2014) definitions for the different methods were used when possible in determining how to categorize certain responses. For example, the survey instrument included an option for "other," and several respondents cited lyric analysis as an "other" method. Because Bruscia defines lyric analysis as a variation of receptive methods, for data analysis purposes those responses were included as part of the respondents' receptive methods percentages. When a respondent provided an "other" response that could fall into more than one category or could not be categorized under any of Bruscia's defined categories, his or her response was left unadjusted. Such responses included "music and recreation," "verbal processing," "art/recreation intervention," and "mindfulness/spiritual practice."

The method percentages shown in the charts were derived by first calculating the overall means for the methods, as well as the method means for the specific theoretical orientations, excluding "other" responses. These will be referred to as the raw means. It needs to be noted that the survey instrument did not force respondents' percentage answers to equal 100. Thus, some respondents' method percentages exceeded 100 and some fell short of 100. After excluding the "other" responses and recognizing that some respondents' reported percentages exceeded 100, the sum of the overall raw means was 97, for the behavioral/cognitive behavioral respondents the sum of the raw means was 103, and for both humanistic/existential and psychodynamic respondents, the sums of the raw means were 98. The raw means were then

Figure 21 – Methods

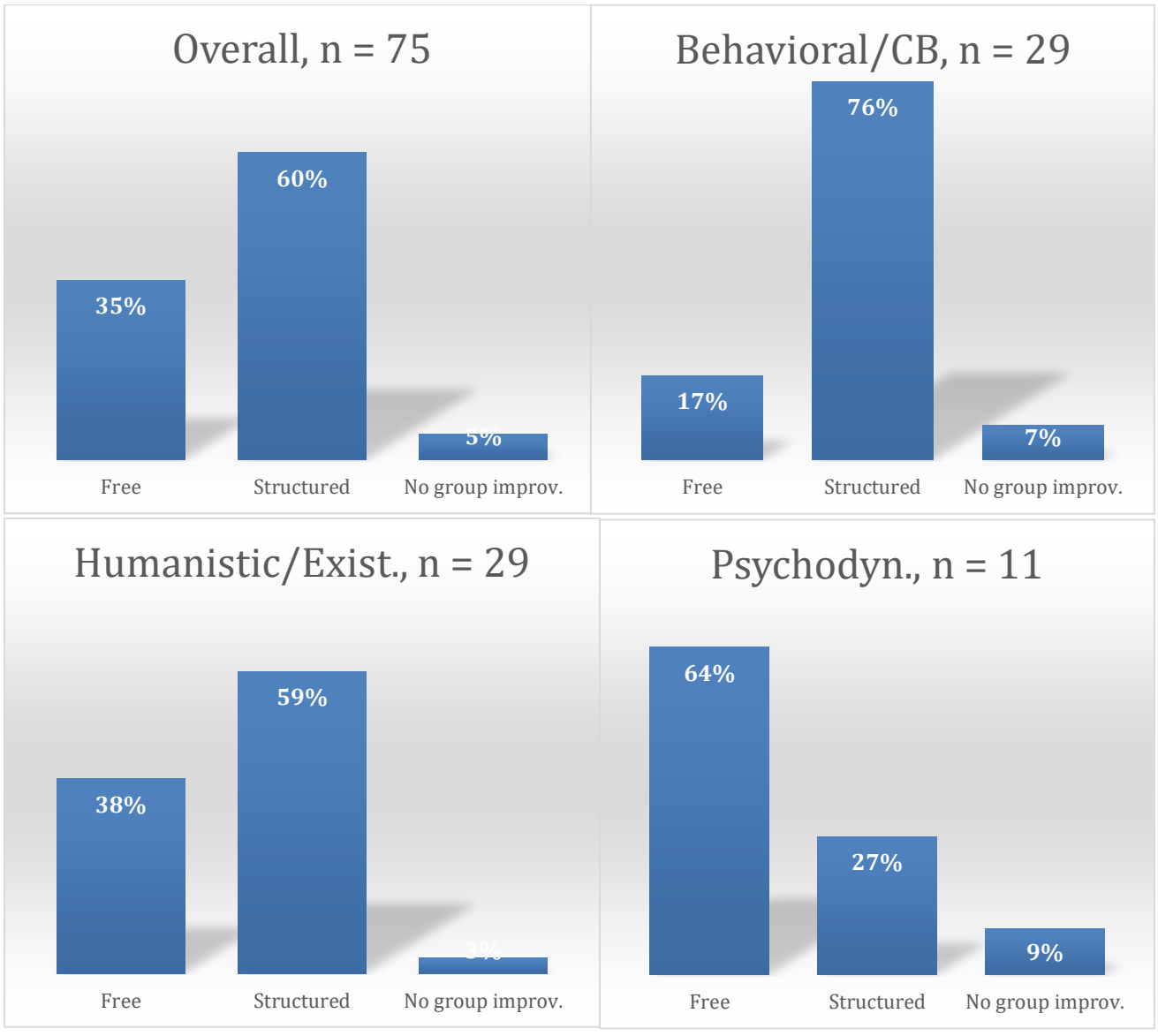


adjusted proportionally so that the overall sum and the sums for the specific orientations equaled 100. These adjusted percentages are what appear in the charts.

The results show a statistically significant difference between theoretical orientations, primarily in the use of improvisation (p = .021), but also with respect to re-creative methods (p = .048). For both behavioral/cognitive behavioral and humanistic/existential orientations, receptive methods were cited as the most frequently used, but for psychodynamic respondents, receptive methods were tied with improvisation as the most frequently used. The least used method for behavioral/cognitive behavioral and humanistic/existential respondents was songwriting, and the least used by psychodynamic respondents was re-creative.

Most respondents overall considered their group improvisations to be structured rather than free (see Figure 22). With respect to this parameter, there was a statistically significant difference (p = .029) among theoretical orientations, with most psychodynamic respondents considering their improvisations to be free. Excluding the two respondents who indicated they do not conduct group improvisations, 81% of behavioral/cognitive behavioral respondents considered their group improvisations to be structured.

Figure 22 – Free or Structured Group Improvisations



Of the 85% of total respondents indicating they conduct group sing-alongs (see Figure 23), 91% reported providing lyrics to group members. For this parameter, there were no statistically significant differences among theoretical orientations. Psychodynamic respondents had the highest percentage indicating they do not conduct group sing-alongs.

When conducting music listening groups, most respondents indicated the music is primarily chosen by group members rather than the music therapist (see Figure 24). Any differences in results relating to theoretical orientation were not statistically significant. The behavioral/cognitive behavioral respondents had the highest percentage reporting that the music is primarily chosen by the music therapist.

Figure 23 – Are Lyrics Provided for Sing-alongs?

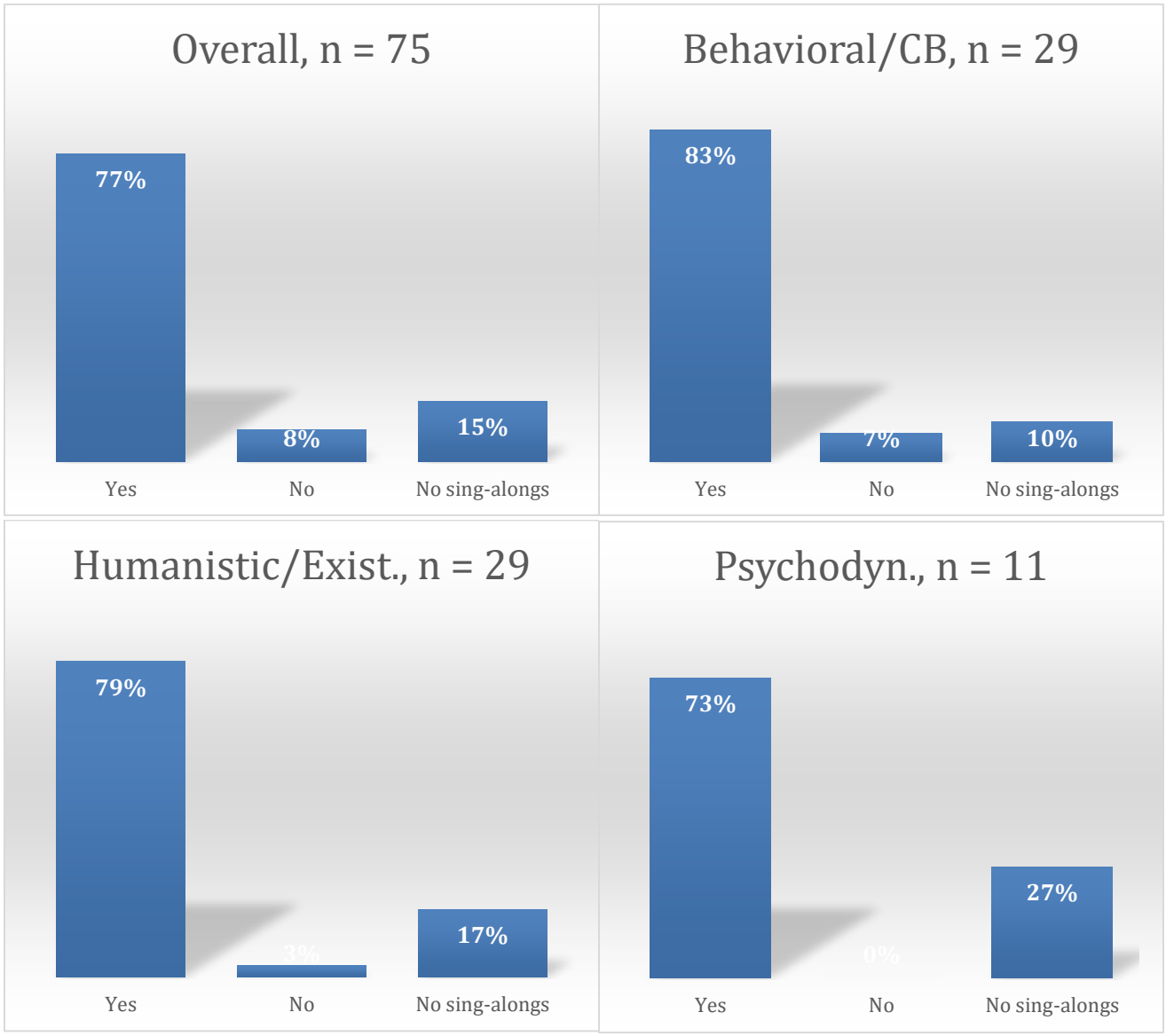


Figure 24 – Music Listening Music Chosen by Group or Music Therapist

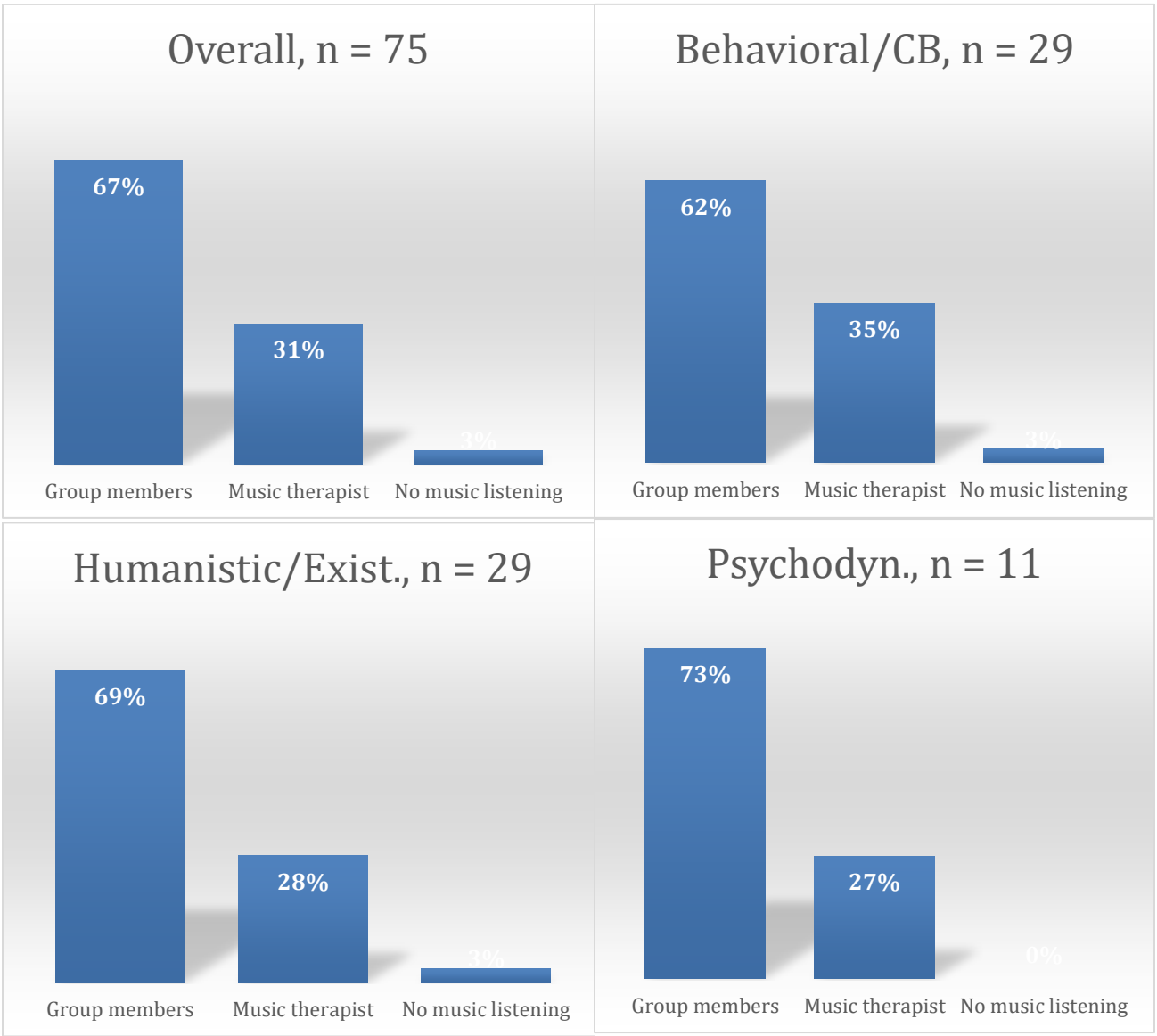
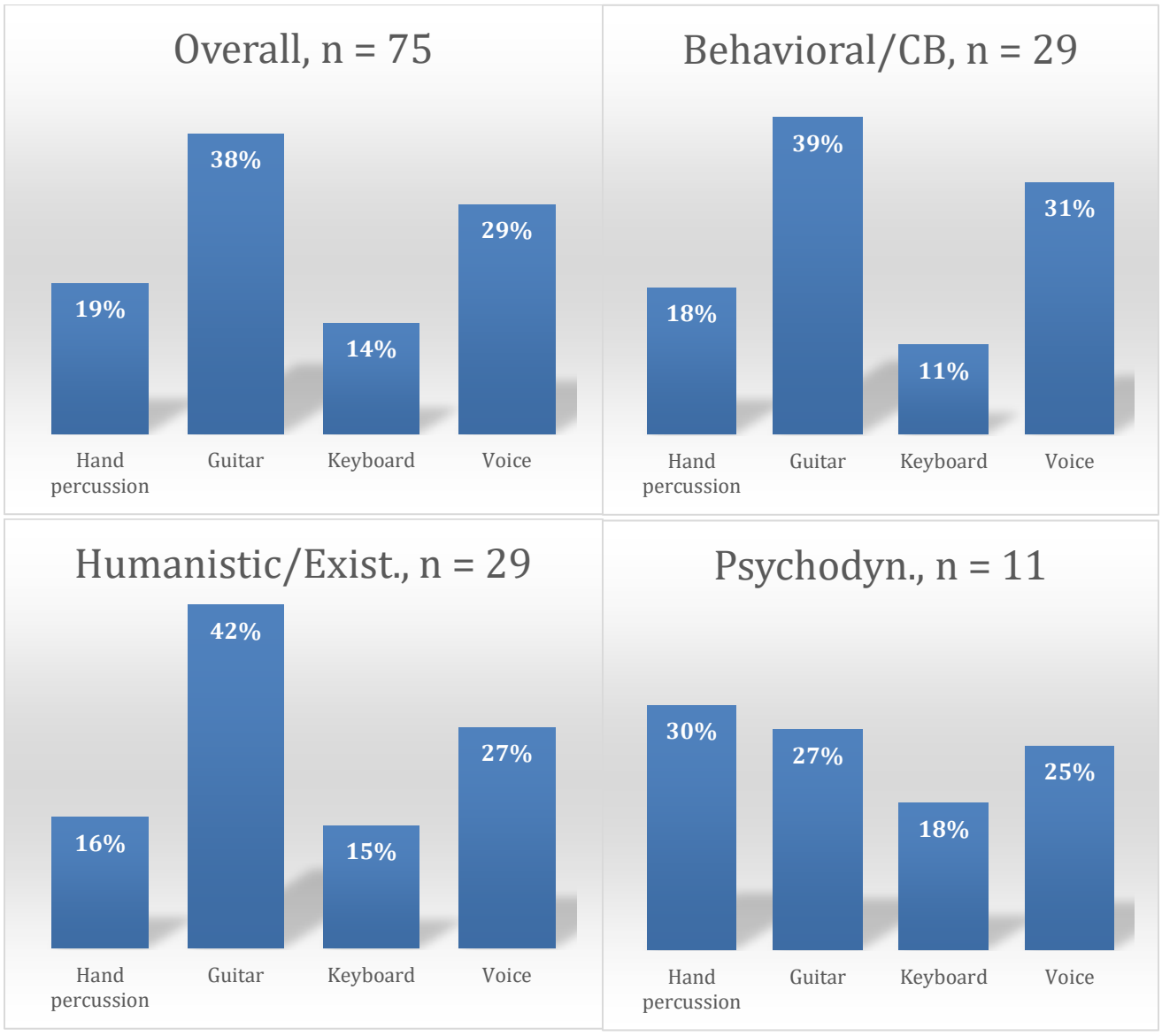


Figure 25 provides a breakout of the main instruments used by respondents overall when they are conducting groups, as well as a breakout of the main instruments used by the different theoretical orientations. The same method was used to derive the percentages appearing in this chart as was used to derive the percentages for Figure 21. Besides the four predesignated instrument choices of hand percussion, guitar, keyboard, and voice, respondents also had the option to provide an "other" response. Such responses included flute, drums, violin, autoharp, dulcimer, ukulele, recorder, "meditation instrument," and "any type of folk instrument."

Once again, the survey instrument did not force respondents' percentage answers to equal 100. With this question, there was some variance in how respondents represented their use of two instruments simultaneously. For example, a respondent who conducts groups by playing guitar and singing could have marked both guitar and voice as 50%, and this is indeed the manner in which most respondents answered. However, some respondents would have marked both guitar and singing as 100% in the prior example. The decision was made to accept both types of responses.

The instrument percentages shown in the charts were arrived at by first calculating the overall means for the instruments, as well as the instrument means for the specific theoretical orientations, excluding "other" responses. Here again, these will be referred to as the raw means. The sum of the overall raw means was 102, for the behavioral/cognitive behavioral respondents the sum of the raw means was 97, for humanistic/existential respondents the sum was 98, and for psychodynamic respondents the sum of the raw means was 128. The raw means were then adjusted proportionally so that the overall sum and the sums for the specific orientations equaled 100. These adjusted percentages are what appear in the chart.

Figure 25 – Main Instrument when Conducting Groups



The results show that guitar and voice appear to be the primary instruments used most frequently by respondents overall. Although the differences among theoretical orientations were not statistically significant, psychodynamic respondents were the highest utilizers of hand percussion and tended to use guitar the least among the different orientations.

Discussion

The survey results indicate that most music therapists working in ACAPFs in the US identify as having either a humanistic/existential or behavioral/cognitive behavioral theoretical orientation. The apparently smaller number of music therapists who identify as psychodynamic working in these facilities could be related to the lack of many patients with acute psychiatric issues having the necessary level of insight into their mental condition that is required for them to be effectively treated using this orientation. Another possible explanation could be that music therapists feel the patients' typical length of stay provides too little time to work effectively in this manner. For those who responded as "other," all but one of their responses could be described as some derivation of "eclectic," and most of the respondents held a bachelor's degree. This finding combines the earlier assertion that a respondent with a bachelor's has likely not had the training in theoretical orientations that someone with a master's has received, as well as Potvin's (2013) point that the field of music therapy in general, at least in the US, has not yet demonstrated a sufficient level of understanding of theory to warrant the inclusion of "eclectic" as an option for designating one's theoretical orientation in a general survey questionnaire.

Demographics

Comparing humanistic/existential and behavioral/cognitive behavioral respondents, with respect to both age and years of experience, those identifying as humanistic/existential tended to be younger and less experienced, while those identifying as behavioral/cognitive behavioral tended to be older and more experienced. Combining these findings with the data showing that the majority of humanistic/existential respondents have master's degrees while the majority of behavioral/cognitive behavioral respondents have bachelor's, one possible explanation for the age and work experience differentials among these orientations could be that this is a result of

the music therapy profession's increasing emphasis on new entrants into the field having a graduate degree. Graduate music therapy programs presumably strive to prepare their graduates to be able to practice at an "advanced" level, as defined by AMTA, and a component of the advanced competencies is a comprehensive knowledge of the different theoretical orientations. Therefore, the music therapists working in ACAPFs who have master's degrees also likely have training in psychodynamic techniques and humanistic philosophy that can be part of their graduate level curriculum. The fact that the respondents from the schools with the highest number of survey participants tended to have theoretical orientations closely aligned with their fellow alumni supports Choi's (2008) finding that the college attended by a music therapist is a major factor in determining his or her theoretical orientation.

Eyre and Lee (2015) did not provide a breakout by age of their respondents. However, if a positive correlation is assumed to exist between age and work experience, because the respondents for the current study overall have less work experience than the respondents in Eyre and Lee's study, one can assume that the respondents for this study are also younger than Eyre and Lee's respondents.

There were some concentrations of theoretical orientations within the AMTA regions. Respondents from the Mid-Atlantic region identified as primarily humanistic/existential, while respondents from the Midwestern, Southeastern, and Southwestern regions identified primarily as behavioral/cognitive behavioral. Respondents from the Great Lakes region were the most evenly split among the three orientations, and respondents from the Western region were evenly split between behavioral/cognitive behavioral and humanistic/existential orientations.

Institution/Working Environment

An ACAPF's underlying theoretical orientation, institutional policies and procedures, and physical configuration can impact the ACAPF's average number of patients per unit, the patients' typical length of stay, the number of weekly music therapy groups offered, the percentage of group/individual sessions offered, and the typical group size. The combination of these factors helps to create the ACAPF's working environment. As the survey results indicate, some working environments appear to be more conducive to certain theoretical orientations.

The need for predictability and control of the musical stimulus as part of the behavioral/cognitive behavioral theoretical orientation could help explain why respondents identifying with that orientation tended to report working on units and conducting groups with smaller numbers of patients, as well as conducting relatively more individual sessions where predictability and control can be more readily achieved, than those identifying as humanistic/existential and psychodynamic. The shorter typical length of stay for patients reported by behavioral/cognitive behavioral respondents could reflect the relatively greater emphasis placed on the therapist/patient relationship as an integral part of the therapeutic process by those with humanistic/existential and psychodynamic orientations. This relationship can be more firmly established through the longer typical length of stay reported by the humanistic/existential and psychodynamic respondents. ACAPFs with shorter typical lengths of stay could therefore have working environments more conducive to a behavioral/cognitive behavioral orientation rather than a humanistic/existential or psychodynamic orientation.

The survey results indicating that a higher percentage of group sessions conducted by both behavioral/cognitive behavioral and psychodynamic respondents relative to humanistic/existential respondents were conducted in some type of enclosed room is consistent

with the behavioral/cognitive behavioral orientation's need for a controlled environment, and with the psychodynamic orientation's emphasis on patients' ability to obtain insight into their condition, which can be hindered by the myriad of distractions that can occur when sessions are conducted in an open dayroom. The humanistic/existential orientation, which can be congruent with concurrently low levels of structure and verbal processing, is the orientation most conducive for groups conducted in open dayrooms.

With respect to music therapists' ability to work in ACAPFs in a manner consistent with their theoretical orientations, while four humanistic/existential respondents indicated they could not work consistent with their orientation because their facility had a behavioral/cognitive behavioral orientation, no behavioral/cognitive behavioral respondents indicated that they were unable to work consistent with their orientation because their facility had a humanistic/existential orientation. One possible explanation could be that a humanistic/existential orientation is more accepting of alternative orientations, and a behavioral/cognitive behavioral orientation is relatively unaccepting of alternative orientations. This explanation is supported by Potvin's (2013) findings that the humanists in his study could be very strongly committed to their own orientation and also be strongly committed to other orientations such as psychodynamic/psychoanalytic and cognitive/behavioral. In contrast, while the cognitive/behaviorists in his study were also strongly committed to their own orientations, very few were also strongly committed to other orientations.

Approaches/Methods

The finding that most respondents identifying as behavioral/cognitive behavioral believed they primarily used music *in* therapy is consistent with Behavioral Music Therapy (BMT) being an example of music *in* therapy. Because all but one of the respondents who were unsure about

whether they used music *as* therapy or *in* therapy also held bachelor's degrees again perhaps points to a lack of exposure at the undergraduate level to this more advanced concept.

The need for predictability and control of the musical stimulus in BMT is consistent with the behavioral/cognitive behavioral respondents having the highest percentages of the three orientations to: 1) consider their groups to be "very structured," 2) develop a plan of interventions/experientials to be used during a session, 3) remain committed to executing the pre-determined session plan once a group is underway, and 4) consider only to "some extent" or "no extent" group members and their presenting mental conditions in determining the particular interventions/experientials to be used once a session is underway.

Survey responses with respect to the importance of group members' musical experiences being generalizable to settings outside of a music setting ran counter to what this researcher expected. Given that generalizability is such a critical, underlying tenet of behaviorism, it was surprising that 17% of respondents identifying as behavioral/cognitive behavioral indicated they believe the generalizability of their group members' musical experiences to be "not important." One possible explanation for this discrepancy could be a lack of knowledge and/or understanding on the part of respondents regarding the philosophical underpinnings of the theoretical orientations they believe they are espousing. Three of the five behavioral/cognitive behavioral respondents who answered that generalizability was "not important" also indicated that they have a bachelor's degree, which could indicate less advanced training in theoretical orientations.

The importance of insight in the psychodynamic therapeutic process is supportive of the results showing that the highest percentage of respondents considering as "very important" the ability of group members to gain some insight regarding their mental condition were the psychodynamic respondents. Similarly, the results indicating that the humanistic/existential

respondents had the highest percentage of respondents considering the importance of group members feeling that they have participated in a creative process to be "very important" also demonstrated an alignment with the underlying tenets of that theoretical orientation.

With respect to the methods used by music therapists in ACAPFs in the US, songwriting appeared as the least used method by two of the theoretical orientations and was used relatively infrequently by the third. This finding is consistent with the need for patients to have a certain level of mental functioning to participate productively in a songwriting experiential, and often patients in ACAPFs do not have the required level of functioning. BMT's need for predictability and control of the musical stimulus was supported by the behavioral/cognitive behavioral respondents indicating that they most frequently use receptive methods. When conducting music listening groups, these respondents indicated that, relative to the other orientations, they most frequently chose the music, rather than having the group members determine what was listened to. To the extent the behavioral/cognitive behavioral respondents conducted group improvisations, most of them considered the improvisations to be structured, rather than free.

Conversely, the use of improvisation to explore and express patients' inner psyches aligns with the finding that, of the different theoretical orientations, the psychodynamic respondents used this method to the greatest extent, and most of them considered their improvisations to be free, rather than structured. A possible explanation for why psychodynamic respondents used re-creative methods the least and had the highest percentage, relative to the other orientations, of respondents indicating they do not conduct group sing-alongs, is due to their work environment not requiring them to use these methods to as great an extent because they are able to conduct their sessions primarily in enclosed rooms, as opposed to open dayrooms. Because of the difficulty in establishing and maintaining group cohesiveness in an

open dayroom setting, the experientials/interventions conducted in these rooms need to accommodate the inevitable ebb and flow of patients into and out of the sessions. Re-creative methods can accommodate such a transient group membership, and this is a possible explanation for why the humanistic/existential respondents, relative to other orientations, utilized these methods to the greatest extent, while also holding the highest percentage of sessions in open dayrooms. A humanistic/existential orientation is the only one of the three focused on in this study to be congruent with concurrently low levels of both structure and verbal processing. For the effective application of a psychodynamic approach, with its reliance on group cohesion being established and maintained, the importance of sessions being conducted in an enclosed room, where the music therapist can serve as the gatekeeper for what patients and staff are allowed to enter the room and to participate in the group, cannot be overemphasized.

The survey results indicating that guitar and voice are the two most frequently used instruments by music therapists in ACAPFs in the US possibly point to the need for musical instruments to be portable in these facilities. With most music therapists working on 2-10 units during a week, and with most units not having a designated music/creative arts room, the need exists for therapists to transport their instruments from unit to unit. If a therapist wants to bring a melodic instrument, a guitar is likely easier to transport than a keyboard.

The relatively greater use of hand percussion instruments by the psychodynamic respondents, combined with their relatively greater use of improvisational methods, aligns with Stephens' (1983) observation that, regardless of training, virtually all patients can participate when percussion instruments are used. Of the three orientations, the psychodynamic respondents reported the highest frequency of being able to conduct sessions in a designated music/creative

arts room, where instruments can likely permanently reside, thus eliminating the need for toting hand percussion instruments from unit to unit.

Conclusions

Implications for Music Therapy

This survey provides a snapshot of the theoretical orientations of music therapists working in ACAPFs in the US, as well as the approaches and methods used by these music therapists, both on an overall basis and differentiated by orientation. Although few of the results attain statistical significance, the data show distinctions among the three highlighted orientations in terms of demographics, working environments, and approaches/methods employed. This study will hopefully serve as a starting point for additional research into how music therapists can provide increasingly effective therapy, and be recognized as such, to this under-researched segment of the mental health population.

The findings of this study support earlier research indicating a need for more training within the US music therapy profession with respect to theoretical orientations. Rather than being merely an esoteric exercise, a substantive knowledge of the underlying tenets of the different orientations can aid a therapist in determining with which orientation(s) he or she feels most comfortable in aligning, and it can provide a framework for deciding what specific experientials/interventions will be most effective, given the therapist's working environment. Whether or not therapists are aware of it, their orientation influences how they interact with their patients/clients. Entering a therapeutic relationship with a therapist who is knowledgeable and comfortable with his or her own theoretical orientation can only be beneficial in the establishment of such a relationship.

Limitations

The researcher cautions readers about the generalizability of the study's results, given the sample size relative to the overall population of music therapists working in ACAPFs in the US,

which is assumed to be small, but is truly unknown. Another possible limitation is that, because definitions and guidelines for completing the survey were not provided to respondents, they had individual discretion in how to answer certain questions regarding their approaches and methods, that is, the two questions pertaining to degrees of structure and the two asking for percentages of methods and instruments used, as well as the question regarding their own theoretical orientation. The survey responses relied upon the respondents' own perceptions of who they are and how they work, and as a result, the reliability of certain responses could be low.

Future Research

Future research needs to focus on the concept of effectiveness. How effective is the music therapy provided in ACAPFs? This survey has demonstrated that music therapy approaches and methods do vary by theoretical orientation. Is one orientation generally more effective than another when working with patients in an ACAPF? Or, are there particular working environments or population subsets where one orientation is generally more effective than another? If so, what are those working environments and populations?

For each ACAPF unit, there is presumably an optimal "music therapy strategy" that can be defined in terms of dosage (number of sessions provided to patients), approaches, and methods. One desired result of the optimal strategy could entail having the highest number of patients involved in music therapy sessions to the greatest extent that they are willing and/or able to participate. How do we, as a profession, determine the components of the optimal strategy?

These are questions that need to be answered as part of building a foundation to a more consistent approach in working with acute psychiatric patients. The development and establishment of a more consistent approach would both be beneficial to patients, as well as help fortify the credibility of music therapists working in ACAPFs.

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APPENDIX A – SURVEY INSTRUMENT

A Survey of Music Therapists' Theoretical Orientations and Practices in Acute Care, Adult Psychiatric Facilities (ACAPF) in the U.S.

1. What is your gender? Male ____ Female _____ Other _____

2. What is your age (in years)?

20-29 ____ 30-39 _____ 40-49 _____ 50-59 _____ > 59 _____

3. What is your highest level of music therapy related education?

Bachelors ____ Masters _____ Doctorate _____

4. From what college/university did you receive your highest music therapy related degree?

(please specify) _____

5. What professional certification do you currently hold?

MT-BC ____ Other (please specify): _____

6. How many years have you worked in an ACAPF?

< 1 ____ 1-5 ____ 6-10 ____ 11-20 ____ >20_____

7. In what AMTA region is your ACAPF located? (please specify)_____

8. Is your ACAPF located in a major metropolitan area? Yes ____ No _____

9. How many hours per week do you work solely in acute care?

<1 _____ 1-8 _____ 9-29 _____ 30-40 ____ >40 ____

10. How many units do you work on during a week?

1 ____ 2-5 ___ 6-10 _____ Other (please specify) _____

11. What is the average number of patients per unit at your ACAPF?

<10 ____ 10-20 ____ 21-30 ___ 31-40 ____ Other (please specify) ____

12. What is the typical length of stay (in days) of patients at your ACAPF?

1-2 ____ 3-7 ____ 8-14 ____ 15-30 ____ >30 _____

13. How many times per week are music therapy groups offered to your units' patients? ____

14. What percentage of your sessions are conducted on a group and individual basis

(percentages should add to 100)? Group _____ % Individual _____ %

15. How many daily sessions, on average, do you conduct? Group ____ Individual ____

16. What is the average length (in minutes) of your sessions? Group ____ Individual ____

17. How many members do your groups typically have?

1-5 ____ 6-10 ___ 11-20 ___ >20 ____

18. Where are your groups usually held?

Open dayroom ____ Enclosed room ____ Designated music/creative arts room ____

Other (please specify) _____

19. What is the primary theoretical orientation you personally align with?

Behavioral/cognitive behavioral _____ Psychodynamic _____

Humanistic/existential _____ Other (please specify) _____

20. Do you work at your ACAPF in a manner consistent with your theoretical orientation?

Yes _____ No _____

21. If your answer to the above question is "no", please explain why: _____

22. In your work, do you primarily use music *as* therapy or *in* therapy?

Music as therapy _____ Music in therapy _____

23. How structured are your group sessions?

Not very structured ___ A moderate amount of structure ___ Very structured _____

24. Prior to a group session, do you develop a session plan of interventions/experientials to be used during the session? Yes _____ No _____

25. If your answer to the above question is "yes", once a group is underway, are you committed to executing the pre-determined session plan? Yes ____ No _____

26. As a group session is underway, to what extent do you consider the group members and their presenting mental conditions in determining the particular interventions/experientials to be used in that session?

To no extent _____ To some extent _____ To a great extent _____

27. When conducting a group, how important is it to you that group members' musical experiences can be generalized to settings outside of a musical setting?

Not important _____ Somewhat important _____ Very important _____

28. When conducting a group, how important is it to you that group members gain some degree of insight regarding their mental condition?

    Not important _____ Somewhat important _____ Very important _____

29. When conducting a group, how important is it to you that group members feel like they have participated in a creative process?

    Not important _____ Somewhat important _____ Very important _____

30. If none of your responses to questions 27-29 was "very important", please describe what your main priority is for group members: _____

31. Approximately what percentage of your work consists of the following methods (percentages should add to 100)? Improvisation _____% Re-creative _____%

    Receptive _____% Songwriting _____%

    Other (please specify method and percentage) _____%

32. Would you describe your group improvisations as being primarily "free" or "structured"?

    Free ____ Structured _____ I do not conduct group improvisations _____

33. When conducting group sing-alongs, do you tend to provide lyrics to the group members?

    Yes _____ No _____ I do not conduct group sing-alongs _____

34. When conducting music listening groups, is the music primarily chosen by you or by the group members? Music therapist _____ Group members ____

I do not conduct music listening groups _____

35. When conducting groups, approximately what percentage of the time do you personally use the following as your main instrument (percentages should add to 100)?

Hand percussion _____% Guitar _____%

Keyboard _____% Voice _____%

Other (please specify instrument and percentage) _____%

APPENDIX B - IRB APPROVAL LETTER

Molloy College

1000 Hempstead Avenue
Rockville Centre, NY 11571
www.molloy.edu

Tel. 516.323.3801
Tel. 516.323.3711

Date: December 11, 2017
To: Professor Heather Wagner for Student Jon Reichert
From: Kathleen Maurer Smith, Ph.D.
Co-Chair, Molloy College Institutional Review Board
Patricia Eckardt, Ph.D., RN
Co-Chair, Molloy College Institutional Review Board

SUBJECT: **MOLLOY IRB REVIEW AND DETERMINATION OF EXEMPT STATUS – MUS 551**
Study Title: **A survey of music therapists working in acute care, adult psychiatric facilities in the United States: Theoretical orientations and practices**
Approved: **December 7, 2017**
Approval No.: **10180509-1211**

Dear Dr. Wagner/ Jon Reichert:

The Institutional Review Board (IRB) of Molloy College has reviewed the above-mentioned research proposal and determined that this proposal is approved by the committee. It is considered an EXEMPT review per the requirements of Department of Health and Human Services (DHHS) regulations for the protection of human subjects as defined in 45CFR46.101(b). Please note that as Principal Investigator (PI), it is your responsibility to be CITI Certified and submit the evidence in order to conduct your research.

You may proceed with your research. Please submit a report to the committee at the conclusion of your project.

Changes to the Research: A change in the research may change the project from EXEMPT status that would require communication with the IRB. It is the responsibility of the Principal Investigator to inform the Molloy College IRB of any changes to this research.

Sincerely,

Kathleen Maurer Smith, Ph.D.

Patricia Eckardt, Ph.D., RN

APPENDIX C – INVITATIONAL EMAIL / CONSENT FORM

Dear Colleague,

This email is an invitation to participate in a brief, anonymous, online survey regarding the theoretical orientations and practices of music therapists working in acute care, adult psychiatric facilities (ACAPF) in the U.S. For this study, an ACAPF is defined as a locked facility or unit, with a typical length of patient stay of 3-30 days. The study is a research project conducted by Jon Reichert, MT-BC, to fulfill his master's thesis requirement as part of the music therapy master's degree program at Molloy College.

The purpose of the study is to: 1) provide an overview of music therapists working in ACAPFs; and 2) determine if there is a relationship between music therapists' theoretical orientations and the approaches/methods used in their clinical work. The results are intended to provide a better understanding of current practices within this under-researched segment of the Mental Health sector, which may inform future practice, training, and research.

You will not be paid for taking part in this study. Your participation is voluntary. If you decide to participate, you will be asked to fill out an online survey, which should take approximately 15 minutes to complete. There are no known risks to participating in this study. Data will be stored securely on Survey Monkey's website, with access only granted to the researcher. Responses will remain confidential. No email addresses will be saved, no IP addresses will be collected, and no individual respondents will be identified. When the study is finished, the data will be erased from Survey Monkey's server, and the researcher's access to the protected site will end.

When you begin the survey, you are consenting to participate in the study. If you do not agree to participate, simply exit now. If, after beginning the survey, you decide that you do not wish to continue, you may stop at any time. You may choose to not answer any question for any reason. If you have any questions prior to or during the study, you may contact Jon Reichert at jreichert@lions.molloy.edu or Heather Wagner (faculty advisor) at hwagner@molloy.edu . If you have any questions or concerns regarding Human Subjects protection, you may contact the Molloy College Institutional Review Board at IRB@molloy.edu or 516-323-3000.

If you wish to receive the results of the study, please contact Jon Reichert. Thank you in advance for your participation and assistance in this research project.

Sincerely,

Jon Reichert, MT-BC
jreichert@lions.molloy.edu

APPENDIX D - REMINDER EMAIL / CONSENT FORM

Dear Colleague,

You recently received an invitation to participate in a brief, anonymous, online survey regarding the theoretical orientations and practices of music therapists working in acute care, adult psychiatric facilities (ACAPF) in the U.S. The study is a research project conducted by Jon Reichert, MT-BC, to fulfill his master's thesis requirement as part of the music therapy master's degree program at Molloy College. This email serves as a reminder to participate. The survey will remain open until February 28, 2018.

The purpose of the study is to: 1) provide an overview of music therapists working in ACAPFs; and 2) determine if there is a relationship between music therapists' theoretical orientations and the approaches/methods used in their clinical work. The results are intended to provide a better understanding of current practices within this under-researched segment of the Mental Health sector, which may inform future practice, training, and research.

You will not be paid for taking part in this study. Your participation is voluntary. If you decide to participate, you will be asked to fill out an online survey, which should take approximately 15 minutes to complete. There are no known risks to participating in this study. Data will be stored securely on Survey Monkey's website, with access only granted to the researcher. Responses will remain confidential. No email addresses will be saved, no IP addresses will be collected, and no individual respondents will be identified. When the study is finished, the data will be erased from Survey Monkey's server, and the researcher's access to the protected site will end.

When you begin the survey, you are consenting to participate in the study. If you do not agree to participate, simply exit now. If, after beginning the survey, you decide that you do not wish to continue, you may stop at any time. You may choose to not answer any question for any reason. If you have any questions prior to or during the study, you may contact Jon Reichert at jreichert@lions.molloy.edu or Heather Wagner (faculty advisor) at hwagner@molloy.edu . If you have any questions or concerns regarding Human Subjects protection, you may contact the Molloy College Institutional Review Board at IRB@molloy.edu or 516-323-3000.

If you wish to receive the results of the study, please contact Jon Reichert. Thank you in advance for your participation and assistance in this research project.

Sincerely,

Jon Reichert, MT-BC
jreichert@lions.molloy.edu